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Supreme Court, U.S.
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No. 00-____

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

ERISA preempts any state law that "relates to" ERISA-covered employee benefit plans, unless the law is within the statute's insurance "saving" clause, which saves from preemption any state law "which regulates insurance." Petitioners include health maintenance organizations ("HMOs") that make limited-size networks of health care providers available to ERISA health benefit plans. Kentucky's "Any Willing Provider" ("AWP") statutes, however, require HMOs to open their networks to *any* provider in the geographical area willing to meet the network contract terms. The Sixth Circuit below unanimously held that Kentucky's AWP statutes relate to ERISA-covered benefit plans, but by a 2-1 decision joined the Fourth Circuit in holding that AWP statutes are not preempted by ERISA because they are laws "which regulate[] insurance," rejecting contrary decisions of the Eighth and Fifth Circuits.

The following question is presented:

Are state "Any Willing Provider" statutes preempted by ERISA, or are they saved from preemption because they are laws "which regulate insurance"?

PARTIES

Petitioners are the Kentucky Association of Health Plans, Inc.; Aetna Health Plans of Ohio, Inc.; Choicecare Health Plans, Inc.; HMPK, Inc.; HPLAN, Inc.; and Humana Health Plan, Inc., all of which were plaintiffs in the district court and appellants in the court of appeals.

Advantage Care, Inc., and FHP of Ohio, Inc., also plaintiffs-appellants below, are no longer parties to this action and are not petitioners in this Court.

Respondent Janie Miller succeeded to the position of Kentucky Commissioner of Insurance after the court of appeals entered judgment in this case, and is accordingly substituted as respondent pursuant to Sup. Ct. R. 35.3.

CORPORATE DISCLOSURE

Petitioner Kentucky Association of Health Plans, Inc., is a nonprofit corporation with no parent corporation. Aetna, Inc., is the parent corporation of petitioner Aetna Health Plans of Ohio, Inc. Humana, Inc., is the parent corporation of petitioners Choicecare Health Plans, Inc.; HMPK, Inc.; HPLAN, Inc.; and Humana Health Plan, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Kentucky Association of Health Plans, Inc., *et al.*, respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the Sixth Circuit is published at 227 F.3d 352 (6th Cir. 2000), and is reprinted in the appendix to this petition ("App.") at 1a. The opinion of the United States District Court for the Eastern District of Kentucky is unpublished and is reprinted at App. 64a. The district court's order of final judgment is unpublished and is reprinted at App. 86a.

STATUTORY PROVISIONS INVOLVED

The relevant provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, are reprinted at App. 88a. The Kentucky Any Willing Provider statutes at issue in this case are reprinted at App. 89a-91a.

JURISDICTION

The opinion and judgment of the court of appeals was entered September 7, 2000. A timely petition for rehearing and suggestion of rehearing en banc was denied by order entered November 20, 2001. App. 87a. On February 12, 2001, Justice Stevens extended the time for filing this petition to March 22, 2001. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

Petitioners are five health maintenance organizations ("HMOs") and a Kentucky-based association of HMOs. As one means of controlling the cost and quality of health-care delivery, petitioners and other HMOs have contracted with

selectively-chosen doctors, hospitals, and other health care providers to create exclusive "provider networks." These "participating providers" are required by their contracts to provide health care services to the HMOs' subscribers at discounted rates and to comply with other contractual requirements. In exchange for their rate discount, participating providers receive the advantage of access to the HMOs' subscribers and, consequently, increased patient volume over non-network providers who lack such access. The value of network membership (and, accordingly, the amount providers will agree to discount their services) depends crucially on the HMOs' ability to limit the number of providers in the network; the fewer the providers, the greater the patient volume for each provider.

Petitioner HMOs make their provider networks available to ERISA-governed employee health benefit plans in two different ways. First, several HMOs contract with ERISA plans to enroll plan beneficiaries as direct subscribers in the HMO. Second, several HMOs make their provider networks available to self-funded employee plans (that is, plans in which benefits are paid for by the employer, rather than the HMO), for which the HMOs provide only administrative services.

The question presented in this case is whether ERISA allows states to enforce laws – called "Any Willing Provider" ("AWP") laws – prohibiting HMOs from limiting the size of the provider networks they make available to ERISA-governed plans and their beneficiaries. A Sixth Circuit panel held below that such laws would appear to be preempted by ERISA in that they "relate to" ERISA plans, but further held – over the dissent of Judge Kennedy – that AWP statutes are laws "which regulate insurance" and therefore are "saved" from preemption by ERISA's insurance-law "saving" clause. The majority's decision exacerbates conflicts in the federal circuits not only over the ultimate question whether AWP

statutes are laws "which regulate insurance" and thus saved from ERISA preemption, but also over a fundamental underlying legal principle that governs that question. The decision below also conflicts with a key precedent of this Court defining the business of insurance. The Court should grant review to resolve the critically important question this case presents.

A. Statutory Background

1. *ERISA Preemption and "Saving" Clause.* As a general matter, ERISA broadly preempts any state law that "relates to" an ERISA-governed employee benefit plan. 29 U.S.C. § 1144(a). Congress, however, chose to save out from ERISA's preemptive force any state law "which regulates insurance." *Id.* § 1144(b)(2)(A). In other words, even if a law otherwise "relates to" an ERISA plan, it is not preempted if it can be understood as a law "which regulates insurance." In ERISA's so-called "deemer" clause, however, Congress further declared that employee benefit plans themselves could not be deemed to be insurance or an insurance company for purposes of the saving clause. *Id.* § 1144(b)(2)(B).

This Court's precedents have erected a "framework for resolving whether a state law 'regulates insurance' within the meaning of the saving clause." *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 367 (1999):

> First we ask whether from a "common sense view of the matter," the contested prescription regulates insurance. Second, we consider three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

Id. (citations omitted); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987).

2. *Kentucky's "Any Willing Provider" Laws.* The Kentucky Legislature enacted the state Health Care Reform Act in 1994. That Act included a general AWP provision, which in its current form provides:

> A health insurer shall not discriminate against any provider who is located within the geographical coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer . . . .

Ky. Rev. Stat. § 304.17A-270. The Act further defines the "insurers" covered by this law as

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to do transact health insurance business in Kentucky.

Ky. Rev. Stat. § 304.17A-005(23).[1] In addition to this general AWP law, in 1996 the Legislature added another AWP provision specifically addressed to contracts between health benefit plans – including HMOs – and chiropractors. *See id.*

[1] The general AWP provision was codified at Ky. Rev. Stat. § 304.17A-110(3) when the complaint in this case was filed. At that time the law applied to "health benefit plans." The legislature subsequently recodified the law at § 304.17A-270, and changed the term "health benefit plans" in the provision to "health insurers," adding a definition of "health insurers" in § 304.17A-005(23). The court below addressed the current language of the statute, agreeing with both parties below that the textual alteration and recodification of this AWP provision did not render the challenge to the AWP laws moot. App. 6a, 40a n.1.

§ 304.17A-171(2). The chiropractic AWP statute does not differ in substance from the general AWP law.[2]

The purpose and effect of the AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the contract terms. Because HMOs' ability to control costs depends in large part on their ability to control the number of providers with network access, as discussed above, *see supra* at 2, the unavoidable consequence of the law is to drive up the costs of the health care services offered by HMOs through provider networks. And HMOs, unable to restrict their networks to providers of their own careful selection, are also less able to regulate and control the quality of care offered by network providers.

B. Proceedings

1. Petitioners filed a complaint in April 1997 in the United States District Court for the Eastern District of Kentucky against the Commissioner of the Kentucky Department of Insurance seeking, *inter alia*, declaratory judgment that Kentucky's AWP laws are preempted by ERISA. The parties cross-moved for summary judgment on the ERISA preemption count. The district court entered an order declaring the challenged laws valid, thus denying petitioners' motion for summary judgment and granting respondent's cross-motion. The court granted petitioners' motion for partial final judgment under Rule 54(b), and entered an order of final

[2] The same Act that established the chiropractic AWP law also included other restrictions on petitioners' freedom to contract with chiropractors. *See* Ky. Rev. Stat. § 304.17A-171(1) & (3)-(8). The court below remanded the issue of whether those provisions are preempted by ERISA. App. 4a n.3. This petition does not raise any preemption question in respect to the remanded provisions of the chiropractic law.

judgment on the ERISA preemption count on September 22, 1998.[3] Petitioners appealed to the Sixth Circuit.

A separate suit challenging Kentucky's AWP laws was filed in December 1996 in the Western District of Kentucky by Community Health Partners, Inc. Judgment was entered in that suit on June 11, 1998, and the plaintiff in that suit also appealed.

2. The instant case and the *Community Health Partners* case were assigned to the same Sixth Circuit panel, which heard argument separately in the two cases. The court issued full majority and dissenting opinions only in this case, however, and incorporated those opinions into its *Community Health Partners* decision.[4]

(a) The panel unanimously agreed that Kentucky's AWP laws "relate to" ERISA plans. App. 7a-19a (majority, per Holschuh, D.J., sitting by designation); *id.* at 39a (Kennedy, J., dissenting). But the majority concluded that those laws are saved from preemption under ERISA's saving clause because they are "laws which regulate insurance."

i. Starting with the "common sense" prong of the insurance saving clause test, the majority focused primarily on the fact that Kentucky's AWP laws apply in terms to "insurers." App. 24a-25a. On that basis alone the court determined that the "Kentucky AWP laws are thus specifically directed toward insurers and the insurance industry and are ones that from a 'common sense view' regulate insurance." App. 25a. Adding further that the AWP laws also "deal directly with the relationship between insurers and insureds under health benefit plans," and "are part of a comprehensive subtitle of

[3] The other counts, which seek declaratory judgment and injunctive relief from the Kentucky AWP laws on other statutory and constitutional theories, remain pending in the district court.

[4] A petition for certiorari was filed in *Community Health Partners* ("*CHP* Pet."), No. 00-1295, 69 U.S.L.W. 3557, on February 12, 2001.

Kentucky's insurance code regulating health benefit plans," the court concluded that for those reasons as well the AWP laws are "clearly laws which, in a common sense view of the matter, 'regulate insurance.'" App. 30a.

In reaching that determination, the panel majority rejected the argument that the AWP laws do not regulate insurance because they apply in fact not just to "insurers" as traditionally understood, but also to employers that pay directly for their employees' health services, to HMOs that provide care rather than indemnification, and to HMOs that act solely as plan administrators and thus provide no benefits to insureds at all. As to the statutes' application to employers, the court concluded that self-funded employers' plans involve "the business of insurance." App. 26a. The court brushed aside ERISA's "deemer clause" – which explicitly prohibits states from deeming self-funded plans to be "insurance" for purposes of the saving clause, *see* 29 U.S.C. § 1104(b)(2)(B) – on the unelaborated ground that the statutory distinction between "insurance" and a self-funded employer plan "is not a distinction based upon a concept that employers who choose to be self-insurers cannot be considered insurers subject to state regulations dealing with insurance." App. 26a. In so holding, the court acknowledged but expressly rejected the contrary conclusion of the Eighth Circuit in *Prudential Insurance Co. of America v. National Park Medical Center*, 154 F.3d 812, 829 (8th Cir. 1998). App. 27a.

As to the laws' application to the two functions HMOs – including petitioners – serve in relation to employee health plans, *see supra* at 2, the court first concluded that HMOs that directly provide medical benefits, while not traditional insurers, "'[i]n the end . . . function the same way as a traditional health insurer.'" App. 23a (quoting *Washington Physician Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1056 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999)). And in respect

to HMOs that provide solely administrative services, the court simply construed the statute as excluding HMOs serving only that function for ERISA plans, App. 26a, 28a n.14, even though both AWP laws specifically include all HMOs within their sweep and neither distinguishes among the services HMOs provide. Despite the fact that even under the court's construction the Kentucky AWP laws apply to HMOs that provide solely administrative services to non-ERISA self-funded plans, the court concluded that the AWP laws are "limited to health care 'insurers.'" App. 28a.

ii. The panel majority then turned to the three McCarran-Ferguson factors. The court found the first – whether the law affects the transfer or spreading of the risk against which the policyholder is insured – to be "certainly a debatable issue," App. 30a, but found it satisfied simply because AWP laws allow insureds to receive covered services from providers for whose services insureds would otherwise have to pay directly. Following an earlier decision of the Fourth Circuit upholding an AWP law against preemption challenge, the panel majority reasoned that AWP laws spread the "cost component" of the policyholder's risk among all insureds, in that the policyholder is not required to shoulder all the cost when seeking care from a provider outside the network. App. 31a (quoting *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993)).

As to the second McCarran-Ferguson factor, the court held that AWP laws govern a practice that is an "integral part of the policy relationship between the insurer and the insured," App. 35a, even while acknowledging that "it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage." App. 36a. The court considered the mandatory change "from a closed pool of providers to an open pool of providers" to be the same as "expanding covered treatment." *Id.*

Finally, bootstrapping its earlier analysis of the laws' application to HMOs and self-funded employer plans under the common-sense prong, the majority concluded that the Kentucky AWP laws are limited to entities within the insurance industry, and thus that the third McCarran-Ferguson factor is satisfied as well. App. 36a.

(b) Judge Kennedy dissented, rejecting the majority's conclusions at every step of the saving clause analysis. She first concluded that "the Kentucky AWP laws do not meet the common sense test because they are directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry." App. 40a. And as applied to HMOs whose only duty is administration, Judge Kennedy reasoned, the AWP laws are "not directed at the business of insurance, as no insurance is involved." App. 43a. In Judge Kennedy's view,

> The common sense conclusion that can be drawn from the AWP statute's coverage of entities clearly operating outside of the business of insurance is that the statute is concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance.

App. 44a.

Judge Kennedy found the majority's treatment of the McCarran-Ferguson factors equally uncompelling. Labeling the "cost component" risk-spreading theory relied upon by the majority as "attenuated," App. 55a, Judge Kennedy observed that "[t]he critical issue with respect to the risk-spreading prong . . . is whether or not the law is related to *the risks underwritten by the insurer*." App. 54a (emphasis added). Health insurance policies underwrite only "the risk that [the] insured will need medical treatment for a condition covered under the policy," App. 56a, and under Kentucky's AWP laws, Judge Kennedy explained, "[t]here is no shifting of [that] risk," *id.*; *see* App. 54a (AWP laws merely "dic-

tat[e] how [insurers] structure their provider networks, irrespective of the risks they underwrite").

As to whether the AWP laws are integral to the insured-insurer relationship, Judge Kennedy considered the matter quite clear:

> Kentucky's AWP provisions leave the contract terms between the insurer and insured[] unaltered. The relationships directly affected by the law are those existing between insurers and third parties (*i.e.*, medical providers). . . . [T]he medical risks covered by the policy remain the same. Thus, even if an insured's preferred provider decides to join the insured's network, and complies with its terms in doing so, the medical coverage that the insurer has contracted to underwrite remains unchanged. . . . Kentucky's AWP laws do not force the insurer to offer a benefit to insureds that was not available before the law.

App. 59a. Finally, also bootstrapping her discussion under the common-sense prong, Judge Kennedy concluded that the AWP laws satisfy the third McCarran-Ferguson factor because they "extend[] to include entities in no way involved in underwriting risks." App. 60a.

REASONS FOR GRANTING THE WRIT

The Court should grant review of this case to resolve a split in the federal circuits, exacerbated by the decision below, over a question of acute importance to health care regulation policy across the Nation, *viz.*, whether states may continue to enact and enforce "Any Willing Provider" restrictions on the ability of health insurers, HMOs, and employers to limit the number of health care providers with whom they contract to provide health care services to employee health

benefit plan beneficiaries.[5] In the face of lawsuits asserting that such laws are preempted by ERISA, the Sixth Circuit in this case and the Fourth Circuit have upheld AWP laws as within ERISA's insurance "saving clause," *see supra* at 6-9; *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993); the Eighth and Fifth Circuit have reached the opposite conclusion, *see Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812, 829 (8th Cir. 1998); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035 (5th Cir.), *cert. denied*, 522 U.S. 820 (1997); *Cigna Healthplan v. Louisiana*, 82 F.3d 642 (5th Cir.), *cert. denied*, 519 U.S. 964 (1996). Not surprisingly, this difference in outcomes also implicates a division over the nature and content of a key legal principle governing the determination whether a law is one which "regulates insurance," a division that extends even beyond the instant context. That conflict has arisen in part because several courts – including the court below – have failed to adhere faithfully to a precedent of this Court squarely holding that third-party provider contracts of the very kind regulated by AWP laws are *not* the "business of insurance." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Review should be granted to resolve the conflict between that decision and the decision below as well.

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[5] The manifest importance of the issue presented here is fully and accurately stated in the *Community Health Partners* petition. *CHP* Pet. 1-2, 25-30. We expect respondent will fully agree that the enforceability of state AWP laws is a question of great significance for health-policy regulation in the many states, including Kentucky, that have chosen to enact such laws.

I. THE COURT SHOULD GRANT REVIEW TO RESOLVE CONFLICTS IN THE FEDERAL CIRCUITS OVER WHETHER AWP STATUTES FALL WITHIN ERISA'S SAVING CLAUSE AND OVER PRINCIPLES GOVERNING SAVING CLAUSE ANALYSIS

Review of this case would enable the Court to address at least two important controversies in the federal circuits over issues squarely presented in this case. The first is a direct split in the circuits over whether AWP laws are preempted by ERISA. The second is a disagreement in principle among the circuits over the question whether laws that affect only the so-called "cost component" of insurance risk satisfy the risk-transfer or risk-spreading prong of the McCarran-Ferguson inquiry.

A. There Is A Square Split In The Circuits Over The Question Whether AWP Statutes Are Laws Which Regulate Insurance

The Sixth and Fourth Circuit have each held that AWP statutes are merely "laws which regulate insurance" and thus are not preempted by ERISA. The Eighth and Fifth Circuits have held to the contrary.

1. The Sixth Circuit panel majority opinion in this case determined that the Kentucky AWP statutes are laws which regulate insurance for the reasons discussed above. *See supra* at 6-9. In so holding, the Sixth Circuit followed the Fourth Circuit's opinion in *Stuart Circle*, which held that a similar AWP law "relates to" ERISA employee benefit plans but is saved from preemption because the law "regulates insurance." *See Stuart Circle*, 995 F.2d at 503-04.

Like Kentucky's law, the Virginia statute at issue in *Stuart Circle* prohibited insurers and benefit plan administrators from entering into exclusive contracts with preferred providers. *Id.* at 501. The court held, first, that the statute "regulates insurance" as a matter of "common sense" because it was "part of a comprehensive code regulating accident and sickness insurance," and because it prohibited insurers from unreasonably restricting the insured's choice of provider. *Id.* at 503. Addressing the McCarran-Ferguson factors next, the *Stuart Circle* court found the first satisfied under the "cost component"/risk-spreading theory followed by the Sixth Circuit in this case – *i.e.*, that by opening up provider networks, AWP laws spread among all insureds the risk that one will be subjected to the cost of care from a nonnetwork provider. *Id.* at 503; *see id.* at 504 (statute "affects the risk that an insured must bear" because it affects "the consequent cost to the insured if he or she deems an excluded provider to be better qualified [than any network provider] for treatment of a specific illness or accident"). The court applied the same rationale to the second factor, reasoning that "treatment and cost" are "integral parts of the relationship between insurer and insured," *id.*, and found the third factor – application to entities outside the insurance industry – satisfied, *id.* at 504, even though the statute applied to HMOs and others acting solely as administrators, Va. Code § 38.2-3407(A).

2. In contrast to the Sixth and Fourth Circuits, the Fifth and Eighth Circuits each have held AWP statutes to be preempted because they are *not* laws which regulate insurance.

(a) In *Prudential Insurance*, *supra*, the Eighth Circuit considered an Arkansas AWP statute that is "almost identical" to Kentucky's, *Ward v. Alternative Health Delivery Sys.*, 55 F. Supp. 2d 694, 701 (W.D. Ky. 1999), but the Eighth Circuit held that the Arkansas law fails both the common sense test and all three McCarran-Ferguson factors, and therefore is not saved from preemption by ERISA.

Applying the common-sense test, the Eighth Circuit found "unpersuasive" the fact that Arkansas' AWP law is "codified as part of the Arkansas insurance code." *Prudential Insurance*, 154 F.3d at 829; *contra* App. 30a (Kentucky

AWP laws satisfy common-sense test in part because they "are part of a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans"); *Stuart Circle*, 995 F.2d at 503 (Virginia AWP law satisfies test in part because it is part of "part of a comprehensive code regulating accident and sickness insurance"). What matters, the court explained, is that the law in fact regulates "far more than just insurance or the insurance industry." *Prudential Insurance*, 154 F.3d at 829. Just as the dissent below argued in respect to Kentucky's law, *see supra* at 9 (quoting App. 44a), the Eighth Circuit reasoned:

> An act that purports to regulate 'health benefit plans' defined so broadly as to include employers and administrators of self-insured plans, as well as traditional insurance, simply does not fit within a common-sense view of a law directed specifically toward the insurance industry.

154 F.3d at 829.

The Eighth Circuit also held that the Arkansas AWP law fails each prong of the McCarran-Ferguson inquiry. In contrast to the "cost component"/risk-spreading theory adopted by the Fourth and Sixth Circuits, the Eighth Circuit held that the AWP law "plainly does not have the effect of transferring or spreading the policyholder's risk." *Id.* Nor, the court explained, is the law integral to the insured-insurer relationship; it affects "only the terms of the relationship between the insurer and a third party, and hence is 'no more "integral" to the insurer-insured relationship' than any contract an insurer might make with any other third party." *Id.* at 830 (quoting *Pilot Life*, 481 U.S. at 50-51); *contra* App. 36a (finding Kentucky AWP laws integral to insurer-insured relationship even though they "do not change the substantive terms of the insurance coverage"); *Stuart Circle*, 995 F.2d at 503 (arguing that "treatment and cost" affected by AWP laws are "integral parts of the relationship between insurer

and insured"). Finally, the Eighth Circuit held that the Arkansas law fails the third McCarran-Ferguson factor because it regulates such non-insurance entities as employers, hospitals, and third-party administrators. 154 F.3d at 830.

(b) The decisions of the Fourth and Sixth Circuit conflict with decisions of the Fifth Circuit as well. In *CIGNA Healthplan*, *supra*, the Fifth Circuit held that a Louisiana AWP law was preempted by ERISA, and the court applied that precedent to reach the same conclusion in respect to a Texas AWP law in *Texas Pharmacy*, *supra*. In both cases the court held that the AWP statutes were not "laws which regulate insurance" because the laws were "not limited to entities within the insurance industry." *Texas Pharmacy*, 105 F.3d at 1038; *see CIGNA Healthplan*, 82 F.3d at 650. The Texas statute, the court explained, also applied "to [HMOs], [PPOs], and other organizations that provide health care services." *Texas Pharmacy*, 105 F.3d at 1038. The court noted that the law also applied to "ERISA benefit plans themselves," *id.* at 1038-39, further noting that "[t]he 'deemer provision' of ERISA prohibits treating ERISA employee benefit plans themselves as being engaged in the business of insurance," *id.* at 1039; *contra* App. 26a (ERISA "deemer clause" does not preclude conclusion that self-funded employer plans are "insurance" for purpose of saving clause); *Stuart Circle*, 995 F.2d at 504 (same). Similarly, the Fifth Circuit reasoned that Louisiana's AWP law fell outside the saving clause because it applied not only to insurers, but also "to 'self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs,' as well as 'health care financiers, third party administrators, providers or other intermediaries.'" *CIGNA Healthplan*, 82 F.3d at 650.[6]

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[6] In both *Texas Pharmacy* and *CIGNA Healthplan*, the Fifth Circuit explicitly evaluated only the third McCarran-Ferguson factor. But its conclusion in both cases that the laws fell outside the saving clause test

3. In addition to the conflict among the federal circuits, federal district courts and state courts have also reached conflicting conclusions in respect to the preemption of AWP laws. *Compare, e.g., Hayden v. Blue Cross & Blue Shield*, 843 F. Supp. 1427 (M.D. Ala. 1994) (Alabama law requiring insurers to reimburse nonnetwork nurses preempted) *with Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 426 S.E.2d 117 (Va. 1993) (no preemption of Virginia AWP law); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 974 F. Supp. 60 (D. Mass. 1997) (no preemption of Massachussetts AWP law); *Witt v. Aetna U.S. Healthcare, Inc.*, 2000 WL 1336491 (D. Me. Sept. 14, 2000) (magistrate op.) (no preemption of Maine AWP law).

4. There are, of course, certain differences in the wording of the various AWP statutes at issue in the decided cases, but the statutes are all essentially the same in operation and effect. Like Kentucky's, they do not alter the terms of insurance contracts, and like Kentucky's, they prohibit not just insurers, but such non-insuring entities as plan administrators and certain self-funding employers from contracting selectively with medical care providers. The question whether such statutes are laws "which regulate insurance" despite such defining features has now been carefully evaluated by

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because they were not limited to the insurance industry would compel the same conclusion under the common-sense prong as well. *See Pilot Life*, 481 U.S. at 50 ("A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must . . . be specifically directed toward that industry."). The Fifth Circuit recently confirmed its agreement on this point. *See Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000) ("The common sense test measures whether the law is specifically directed toward the insurance industry."), *petition for cert. filed*, No. 00-665, 69 U.S.L.W. 3317 (Oct. 24, 2000). *Corporate Health* holds that a state law necessarily falls outside the saving clause if it "cover[s] employers and others not engaged in insurance practices," 215 F.3d at 538, and explicitly reaffirms *Texas Pharmacy* and *CIGNA Healthplan* on that basis, *id.* at 538 & n.51.

four separate federal circuits and numerous other courts. There is no reason to await further development of this issue in the courts. Nobody can dispute that continued uncertainty over the enforceability of AWP laws harms the interests of states, employers, health benefit and service providers, and patients and beneficiaries. The conflict is ripe for resolution by this Court.

B. The Circuits Are Divided Over The Substantive Content Of The McCarran-Ferguson Risk-Spreading Factor

1. As discussed above, both the opinion of the Sixth Circuit in this case, and the Fourth Circuit opinion on which it relies, explicitly turn in part on the view that AWP laws affect the risk-spreading aspect of the insurance relationship. According to these opinions, by requiring managed care entities to open their provider networks to any willing provider, AWP laws "affect[] the risk that an insured must bear" because they remove "the consequent cost to the insured if he or she deems an excluded provider to be better qualified [than any network provider] for treatment of a specific illness or accident." *Stuart Circle*, 995 F.2d at 504.

The Tenth Circuit has adopted the same broad view of risk-spreading in a related context. *See Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986). *Bell* held that a Kansas statute requiring insurance companies to pay for the services of certain specified providers (a "mandated-provider" statute) qualifies for ERISA saving clause protection as a law which regulates insurance. Analyzing the risk-spreading component of the McCarran-Ferguson test, the court explained that an insurance policy transfers "the risk that an individual may need [particular] care," and that "[i]mplicit in the coverage of [such] care is the insured's choice of a deliverer of the care." *Id.* at 1335. "The choice of provider," in other words, "does not add to the insured's

coverage but is of the essence of that coverage bargained for as the transferred risk." *Id.*

2. This expansive view of the McCarran-Ferguson risk-spreading factor conflicts with the views of at least three other circuits. In *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998), *cert. denied*, 526 U.S. 1086 (1999), the Ninth Circuit explained that "the term 'risk' – as used in this factor – refers to the *risk of injury* for which the insurance company contractually agreed to compensate the insured," *id.* at 945-46 (emphasis added). While the California "notice-prejudice" law at issue in that case – prohibiting a denial of benefits for late-filed claims of which the insurer had timely notice, absent prejudice to the insurer – did shift away from the insured the risk of lost coverage for untimely claims, the court held that it failed the McCarran-Ferguson risk-spreading factor because it did not "alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability." *Id.* at 946.[7]

The Eleventh Circuit used similar reasoning in *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir. 1994), to hold that a Georgia law requiring written notice of insurance coverage cancellation fails the risk-spreading factor. Like the Ninth, the Eleventh Circuit emphasized that "the risk-spreading principle concerns . . . the risks of injury that the insurance company will bear for the insured." *Id.* at 569.

And, though the Eighth Circuit's opinion finding Arkansas' AWP law outside the saving clause did not address the broad cost-component/risk-spreading theory in terms, its opinion evinces no uncertainty on the matter: the AWP statute "plainly does not have the effect of transferring or spreading the policyholder's risk." *Prudential Insurance*, 154 F.3d at 829.

[7] The Ninth Circuit ultimately held that the notice-prejudice rule nevertheless fell within the saving clause because it satisfied all the other elements of the saving clause inquiry. *See Cisneros*, 134 F.3d at 945-47. This Court affirmed that conclusion in *UNUM*, *see* 526 U.S. at 368-75, but declined to address the Ninth Circuit's risk-spreading analysis, *see id.* at 374.

Review of this case would enable the Court not only to resolve the conflict over the preemption of state AWP laws, but also to provide further guidance as to the nature of the risk-spreading factor so critical to the insurance saving clause inquiry in any context. As cases like *Bell*, *UNUM*, and *Jefferson Pilot* demonstrate, such guidance will help to clarify the resolution of saving clause issues that arise in respect to a variety of state health care regulatory statutes. Review should be granted for that reason as well.

II. THE COURT SHOULD GRANT REVIEW TO RESOLVE A CONFLICT BETWEEN THE DECISION BELOW AND A DECISION OF THIS COURT

As the opinion below candidly acknowledges, the Kentucky AWP laws do not alter any term of any agreement between insurer and insured. App. 36a ("it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage"). Rather, the only contracts "directly affected by the law[s] are those existing between insurers and third parties (*i.e.*, medical providers)." App. 59a (Kennedy, J., dissenting). Nevertheless the panel majority, like the Fourth Circuit, concluded that AWP laws do regulate "the business of insurance" as that phrased is used in the McCarran-Ferguson Act, 15 U.S.C. § 1012(b).

This Court has already squarely held, however, that agreements between insurers and third-party service providers are *not* "the 'business of insurance'" under McCarran-Ferguson. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The decision below directly conflicts with *Royal Drug*.

1. The insurance company in *Royal Drug* provided a $2 prescription drug benefit as part of its plan, and it contracted

with a limited set of pharmacies to provide drugs to beneficiaries at that $2 price. When a nonparticipating pharmacy challenged that arrangement as a violation of the antitrust laws, the insurance company argued that its pharmacy agreements were sheltered from the antitrust laws by the McCarran-Ferguson Act exemption for the "business of insurance." This Court held, however, that contracts between insurers and providers are not the "business of insurance."

The Court's analysis began with the "underwriting or spreading of risk," which, the Court explained, is "an indispensable characteristic of insurance." *Id.* at 212. The pharmacy provider agreements are not the business of insurance because they "do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by [the insurer]." *Id.* at 214. So long as the insurance company's promise to cover the cost of prescription drugs except for the $2 charge is kept, beneficiaries "are basically unconcerned with arrangements made between [the insurer] and participating [providers]." *Id.* The Court also explained that even though the provider agreements reduce the cost of the risk of needing prescription drugs (a cost that is spread among all insureds), that argument "proves too much," *id.* at 216:

> If agreements between an insurer and retail pharmacists are the "business of insurance" because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control – whether with automobile body repair shops or landlords.

Id. at 232.

2. The decision below cannot be reconciled with *Royal Drug*'s analysis of third-party provider agreements and the "business of insurance." The third-party health care provider contracts at issue here are indistinguishable from the third-party pharmacy provider contracts at issue in *Royal Drug*.

Indeed, the Court explicitly recognized as much in *Royal Drug* itself:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders – *such as agreements with hospitals, doctors, lawyers, and the like.*

Id. at 232 n.40 (emphasis added); *see id.* at 215 (suggesting that it would not be the "business of insurance" if "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain"); *cf. id.* at 243 (Brennan, J., dissenting) ("The Court . . . today holds that *no provider agreements* can be considered part of the 'business of insurance.'" (emphasis added)). If an insurer's agreement with an exclusive set of providers to provide services to policyholders is not the "business of insurance," then a law which regulates such an agreement cannot be a law which regulates insurance.

The single distinction suggested by the majority opinion below only confirms the controlling force of *Royal Drug* in this context. According to the Sixth Circuit, the sole difference between the provider agreements in the two cases is that the insurer in *Royal Drug* "did not restrict the number of providers in question." App. 32a. Thus, the majority below reasoned, the "benefit conferred on the insureds by the Kentucky AWP statutes – removal of restrictions on the number of providers – was already present in *Royal Drug*." *Id.* That "distinction" wholly misses the point: if what insurers were doing in *Royal Drug* was *not* the "business of insurance," a law requiring insurers to do exactly what the insurers in *Royal Drug* were doing cannot be a law regulating the "business of insurance." The proper question is simply whether contracts between an insurer and a network of third-party

providers is part of the business of insurance. *Royal Drug* explicitly answers that question no, and that answer must govern here.[8]

3. This Court's opinion in *Royal Drug* also conflicts with the logic of the "cost component"/risk-spreading analysis of third-party provider contracts adopted by the Sixth Circuit in this case, and by the Fourth and Tenth Circuits as well. *See supra* at 17-18. The terms of the provider agreements at issue in *Royal Drug* necessarily limited the size of the provider network, *Royal Drug*, 440 U.S. at 209, which reduced the costs to all insureds in part by shifting to some insureds the cost of obtaining prescription drugs from non-network providers, *id.* at 214, 216. But such cost savings, the Court made clear, "do not involve any underwriting or spreading of *risk*," *id.* at 214 (emphasis added) – *i.e.*, "the risk that policyholders will be unable to pay for prescription drugs during the period of coverage," *id.* at 213. That risk is

[8] The decision below suggests that the *Royal Drug* may not be controlling because in *United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993), this Court "distinguished *Royal Drug* on the ground that it was an antitrust law case, and the Court in that case was construing the words, 'the business of insurance' contained in the second clause of § 2(b) of the McCarran-Ferguson Act, the antitrust law exemption," App. 35a, whereas the "first clause, which commits laws 'enacted by any State for the purpose of regulating the business of insurance' to the States is, according to the Supreme Court, 'not so narrowly circumscribed,'" *id.* (quoting *Fabe*, 508 U.S. at 504). But *Fabe*, if anything, only underscores the vitality of the *Royal Drug* analysis. First, *Fabe* itself explicitly reaffirms *Royal Drug*'s holding that "an insurer's agreements with participating pharmacies to provide benefits to policyholders [i]s not part of the business of insurance." *Fabe*, 508 U.S. at 503. Second, the language of ERISA's saving clause does *not* address laws with the "purpose" of regulating insurance – as does the second clause of the McCarran-Ferguson Act at issue in *Fabe* – but instead only those that actually do "regulate insurance." Finally, this Court since *Fabe* has applied the test derived directly from *Royal Drug*'s analysis of the "business of insurance" to determine whether a law is one "which regulates insurance" under ERISA's saving clause. *See UNUM*, 526 U.S. at 367.

entirely unaffected by the provider agreements. Thus, despite the inherent cost-shifting effect of provider agreements, a law regulating such agreements does not regulate the spreading of the risk against which beneficiaries are insured, and therefore does not regulate the business of insurance. *See* App. 56a (Kennedy, J., dissenting) ("The insurance policy and the contingencies it underwrites, *i.e.*, the risk that insured[s] will need medical treatment for a condition covered under the policy, remain the same, regardless of Kentucky's AWP law."); *Express Scripts, Inc. v. Wenzel*, 102 F. Supp. 2d 1135, 1153 (W.D. Mo. 2000) ("The Any Willing Provider statute would . . . have the likely effect of increasing the number of general practitioners from whom the insured could choose. However, even without the statute, the insured would be able to see a general practitioner in the insurance company's network. Thus, in either case, the risk that the insured will need to see a general practitioner is borne by the insurance company. This is why Any Willing Provider statutes do not spread risk.").

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC.; ADVANTAGE CARE, INC.; AETNA HEALTH PLANS OF OHIO, INC.; CHOICECARE HEALTH PLANS, INC.; FHP OF OHIO, INC.; HMPK, INC.; HPLAN, INC.; HUMANA HEALTH PLAN, INC.,
Plaintiffs-Appellants,
v. No. 98-6308

GEORGE NICHOLS, III, in his official capacity as Commissioner of the Kentucky Department of Insurance,
Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Kentucky at Frankfort.
Nos. 97-00024-Joseph M. Hood, District Judge.

Argued: September 20, 1999

Decided and Filed: September 7, 2000

Before: KENNEDY and NORRIS, Circuit Judges; HOLSCHUH,* District Judge.

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* Honorable John D. Holschuh, United States District Judge for the Southern District of Ohio, sitting by designation.

COUNSEL

ARGUED: Robert N. Eccles, O'MELVENY & MYERS, Washington, D.C., for Appellants. Shaun T. Orme, KENTUCKY DEPARTMENT OF INSURANCE, Frankfort, Kentucky, for Appellee. **ON BRIEF:** Karen M. Wahle, O'MELVENY & MYERS, Washington, D.C., Barbara Reid Hartung, GREENEBAUM, DOLL & MCDONALD, Louisville, Kentucky, for Appellants. Shaun T. Orme, Anna R. Gwinn, KENTUCKY DEPARTMENT OF INSURANCE, Frankfort, Kentucky, for Appellee.

HOLSCHUH, D.J., delivered the opinion of the court, in which NORRIS, J., joined. KENNEDY, J. (pp. 38-61), delivered a separate dissenting opinion with respect to Part III of the majority opinion.

OPINION

HOLSCHUH, District Judge. Plaintiffs are seven health maintenance organizations (HMOs) licensed under the laws of Kentucky, and the Kentucky Association of Health Plans, Inc., a non-profit association organized to promote the business interest of its HMO members (hereinafter referred to as "plaintiffs"). Plaintiffs filed this action against George Nichols III ("defendant"), in his official capacity as Commissioner of the Kentucky Department of Insurance. Plaintiffs argued that Kentucky Revised Statutes Annotated §§ 304.17A-110(3) and 304.17A-171(1)-(8) (Banks-Baldwin 1995), should be found preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), and sought injunctive relief from their enforcement. Both parties moved for summary judgment. The district court denied plaintiffs' request for summary judgment and granted defendant's cross-motion for summary judgment, concluding that §§

304.17A-110(3) and 304.17A-171(2) were saved from preemption by ERISA because they "regulated insurance" under ERISA's savings clause. Plaintiffs assert that the district court erred in this conclusion.

I. The State Statutes

In 1994, the Kentucky General Assembly enacted the Kentucky Health Care Reform Act (the "Act"). The Act contained an "Any Willing Provider" provision that stated: "Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan." Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995). The Act defined a health benefit plan as:

> [Any] hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160. § 304.17A-100(4)(a) (Banks Baldwin 1995).

In 1996, the Kentucky General Assembly added §§ 304.17A-170 and 171 to the code. The additions specifically regulate how "health benefit plans" can interact with chiropractors.[1]

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[1] Section 304.17A-170(1) states that "health benefit plan" has the same meaning as in § 304.17A-005, which provides in pertinent part:

Not only does the statute contain an "any willing provider" provision addressed particularly to chiropractors,[2] but it also imposes various additional requirements on health benefit plans that include chiropractic benefits.[3] See § 304.17A-171.

> "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky . . . .

§ 304.17A-005(17) (Banks Baldwin 1999).

[2] The "any willing provider" provision of § 304.17A-171(2) states: A health benefit plan that includes chiropractic benefits shall:

> (2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

[3] Specifically, health benefit plans are required to: include all primary chiropractic providers who are selected by a person covered by the plan; allow participants direct access to chiropractors of their choice without referral from a gatekeeper; appoint a chiropractor as a gatekeeper for the provision of chiropractic services when the plan uses gatekeepers; refrain from discriminating in reimbursement rates between chiropractors; refrain from promoting or recommending any chiropractor to a covered person; assure adequate numbers of providers are included in the plan; and make listings of participating chiropractors available to covered persons on a regular basis. § 304.17A-171(1) & (3)-(8).

In April of 1997, plaintiffs filed suit in the Eastern District of Kentucky, requesting that § 304.17A-110(3) and § 304.17A-171 (for convenience we will collectively refer to § 304.17A-110(3) and § 304.17A-171(2) as Kentucky's "AWP" laws) be declared, among other things, preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a). Plaintiffs moved for partial summary judgment on the issue and Commissioner Nichols cross-moved for partial summary judgment as well. The district court determined that while the Kentucky AWP laws were related to employee benefit plans under ERISA § 514(a), they regulated the business of insurance and therefore fell under the saving clause of § 514(b), 29 U.S.C. § 1144(b)(2)(A). The court thus granted partial summary judgment in favor of Commissioner Nichols and determined its order to be final and appealable. This appeal followed.

Sections 304.17A-110(3) and 304.17A-100(4)(a) were repealed by the Kentucky legislature effective July 1, 1999. The parties acknowledge that this appeal is not moot, however, as the legislature, through House Bill No. 315 (Ky. 1998), replaced the repealed provisions with the same requirements, but substituted the term "health insurer" for "health benefit plan" in its any willing provider provision, now located at Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999). The Bill's definition of "insurer" was codified at Kentucky Revised Statutes Annotated § 304.17A-005(22) (Banks-Baldwin 1999), which

The district court apparently limited its analysis to Kentucky's "Any Willing Provider" provisions, the general provision being located at § 304.17A-110(3) and the specific chiropractic provision being located at § 304.17A-171(2). The district court noted that the chiropractic statute imposed additional requirements, beyond those imposed by the general "any willing provider" statute, but because both statutes "similarly define 'health benefit plan'" the court referred to those statutes collectively. J.A. at 35. Because the court never explicitly addressed provisions (1) and (3)-(8) of § 304.17A-171, the chiropractic statute, we will remand the issue of their preemption for consideration in the first instance by the district court.

defines "insurer" as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from-state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

The parties having agreed that this appeal is not rendered moot by the new language used in the present statutes, the court will consider the AWP laws in their present form in the court's analysis of their validity, rather than adjudicating the validity of repealed statutes.

The chiropractic provisions contained in § 304.17A-171 and § 304.17A-170 were left intact by House Bill No. 315 and continue to remain unchanged.

The issue of the potential preemption of §§ 304.17A-270 and 304.17A-171(2) by ERISA is therefore properly before this court.[4] We review a district court's decision to grant summary judgment *de novo*, applying the same test as that employed by the district court. *Wathen v. General Elec. Co.*, 115 F.3d 400, 403 (6th Cir. 1997). Summary judgment is proper if there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. *See Schachner v. Blue Cross & Blue Shield of Ohio*, 77 F.3d 889, 892-93 (6th Cir. 1996).

[4] The appeal taken from *Community Health Partners v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991(W.D. Ky.1998), raised the question of whether § 304.17A-110(3) (replaced by § 304.17A-270) was preempted under ERISA and was argued the same day as this case. As a result, this opinion will necessarily dictate the outcome of that case as well.

II. Preemption

We are required by this appeal to define the boundaries of preemption under ERISA § 514 (a) and (b), 29 U.S.C. § 1144(a) and (b). Section 514(a), the preemption provision, reads:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title (emphasis added).

Section 514(b)(2)(A), the "savings" provision, reads:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

Section 514(b)(2)(B), the "deemer" provision, reads:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other tnan a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The federal courts have addressed the scope of ERISA's preemption of State law on numerous occasions; however, the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear

boundaries. Many courts, including the Supreme Court, have commented on the vexingly broad and ambiguous nature of the provisions.[5] Despite such interpretational difficulties, we must determine whether Kentucky Revised Statutes Annotated §§ 304.17A-270 and 304.17A-171(2) (Banks-Baldwin 1999) "relate to" employee benefit plans covered by ERISA. If so, then the provisions are preempted, unless they fall under ERISA's saving clause as laws regulating insurance.

ERISA is a comprehensive act designed to regulate employee welfare and pension benefit plans, including those that provide "'medical, surgical, or hospital care or benefits'" for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.' *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51, 115 S. Ct. 1671, 1674, 131 L. Ed. 2d 695, 702 (1995) (discussing and quoting ERISA § 3(1), 29 U.S.C. § 1002(1)). To assure that the regulation of employee welfare benefits would remain an area of exclusive federal concern, Congress passed § 514(a) of ERISA, the preemption provision.

The Supreme Court has specifically found that in passing

[5] *See, e.g., California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335-36, 117 S. Ct. 832, 843, 136 L. Ed. 2d 791, 805-06 (1997) (Scalia, J., concurring) (noting that the Court had taken 14 previous cases regarding ERISA preemption, and suggesting that neither the Court's prior decisions, nor its present one, succeeded in bringing clarity to the law); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 1677, 131 L. Ed. 2d 695, 705 (1995) (remarking on the unhelpful nature of the statute's text and the frustrating difficulty of defining its key terms); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728, 740 (1985) (observing that the provisions were "not a model of legislative drafting"); *Prudential Ins. Co. of Am. v. National Park Med. Ctr., Inc.*, 154 F.3d 812, 818 (8th Cir. 1998) (comparing efforts to discern the scope of ERISA preemption to unraveling the fabled Gordian knot).

§ 514(a) it was Congress' intent:

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Travelers, 514 U.S. at 656-57, 115 S. Ct. at 1677, 131 L. Ed. 2d at 706 (alteration in original) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 484, 112 L. Ed. 2d 474, 486 (1990)). In discussing the preemption provision, the Court has variously noted its extreme breadth, terming it "clearly expansive," "broad [in] scope," "broadly worded," "deliberately expansive," and "conspicuous for its breadth." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, Inc., 519 U.S. 316, 324, 117 S. Ct 832, 837, 136 L. Ed. 2d 791, 799 (1997) (internal citations omitted) (reviewing past Supreme Court case law addressing the scope of ERISA's preemption provision). The preemption provision, however, is not without limits. As the Court noted in *Travelers*, § 514(a) preempts all state laws that relate to an employee benefit plan covered by ERISA, but, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course." 514 U.S. at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705.

Thus, to determine whether a law "relates to" an employee benefit plan, the Court has formulated a two part test, under which a "law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a *connection with* or [2] *reference to* such plan." *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799 (internal quotations and citations omitted) (emphasis added). The district court

found, and plaintiffs argue, that the Kentucky AWP provisions both refer to and have a connection with ERISA covered employee benefit plans.[6] We analyze each prong of the "relation to" test in turn.

A. Reference To

The Supreme Court has provided guidance in several cases as to when a law "refers to" ERISA. In *Dillingham* the Court summarized its analysis, stating:

> [W]e have held preempted a law that "impos[ed] requirements by reference to [ERISA]," *District of Columbia v. Washington Bd. of Trade*, 506 U.S. 125, 130-31 (1992); a law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision, *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828 n.2 (1988); and a common-law cause of action premised on the existence of an ERISA plan, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990). Where a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Bd. of Trade* and *Ingersoll-Rand*, that "reference" will result in preemption.

519 U.S. at 324-25, 117 S. Ct. at 837-38, 136 L. Ed. 2d at

[6] The Western District of Kentucky in *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991, 995-1001 (W.D. Ky. 1998), also found the AWP provisions "related to" ERISA plans, but only under the "connection with" prong of the "relation to" analysis. That court did not believe that the statute referred to ERISA plans in the manner that Supreme Court precedent requires for preemption under the "reference to" prong. Specifically, the court believed that under Dillingham, a law will only "refer to" an ERISA plan for preemption purposes if it "acts immediately and exclusively upon ERISA plans" or "where the existence of ERISA covered plans is essential to the law's operation." *Id.* at 995-96. We disagree with the district court's "reference to" analysis for the reasons set forth in this opinion.

799.

In *Mackey v. Lanier Collection Agency & Service,* Inc., 486 U.S. 825, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988), the Court discussed Georgia Code Annotated § 18-4-22.1(1982), which specifically exempted ERISA plans from Georgia's general garnishment law. The Court noted that even though Georgia's legislature may have enacted § 18-4-22.1 to help effectuate ERISA's underlying purpose, it would still be preempted if it fell within ERISA's preemption provision. Finding that § 18-4-22.1 was indeed preempted, the Court stated:

> [A]dhering to our precedents in this area, we hold Ga. Code Ann. § 18-4-22.1, which singles out ERISA employee welfare benefit plans for different treatment under state garnishment procedures, is preempted under § 514(a). The state statute's express reference to ERISA plans suffices to bring it within the federal law's preemptive reach.

Mackey, 486 U.S. at 830, 108 S. Ct. at 2186, 100 L. Ed. 2d at 844. In a footnote, the Court indicated that the "different treatment" was illustrated not just by the express reference to ERISA plans in the statute's language, but also in the disparate treatment accorded to non-ERISA pension and benefit plans under Georgia law. *See id.* at n.4. The effect was that only ERISA welfare benefit plans were singled out for protection under the statute, an impermissible result.

The district court in the case at bar relied on *Mackey* in determining whether Kentucky's AWP statutes referred to an ERISA plan. The district court first observed that under Kentucky's statute, "health benefit plans" were defined to include, among other things, "a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA." Based on this language, the court concluded that "it is clear that the AWP statutes 'refer to' ERISA employee benefit plans." In support, the court cited *De Buono v. NYSA-ILA Medical & Clinical Services*

Fund, 520 U.S. 806, 815, 117 S. Ct. 1747, 1752, 138 L. Ed. 2d 21, 30 (1997), which cited *Mackey* for the principle that a provision that explicitly refers to ERISA in defining the scope of the state law's application is preempted.

The district court noted that the Western District of Kentucky in *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991 (W.D. Ky. 1998), disagreed with its analysis of the same statute. The *Community Health Partners* court, relying on language in *Dillingham*, found that Kentucky's AWP statute did not "refer to" an ERISA plan because the law did not act "immediately and exclusively upon ERISA plans" and because the existence of ERISA plans was not essential to the law's operation. *Id.* at 995-96. However, the district court in the present case disagreed with the *Community Health Partners* court, finding that "*Mackey* makes it clear that when a statute 'singles out ERISA employee benefit plans for different treatment' the statute's 'express reference to ERISA plans suffices to bring it within the federal law's preemptive reach.'" J.A. at 12 n.6.

Other courts have reached similar conclusions. The Eighth Circuit in *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), found that an Arkansas AWP statute containing language comparable to Kentucky's provisions was preempted due to its reference to employee benefit plans covered by ERISA. The court noted that the law expressly stated its provisions "shall not apply to self-funded or other health benefit plans that are exempt from state regulation by virtue of [ERISA]." *Id.* at 822. Accordingly, the court determined that § 23-99-209 of the Arkansas Patient Protection Act ("PPA") referred to ERISA plans, as it "undeniably makes an express reference to ERISA and attempts to exclude from coverage of the PPA at least some ERISA plans. Thus it 'singles out ERISA employee benefit plans for different treatment under state [law], [and therefore] is preempted under § [

1144(a)].'" *Id.* at 824 (quoting *Mackey*). *See also Cigna Health Plan of La., Inc. v. Louisiana*, 82 F.3d 642, 647-48 (5th Cir. 1996) (concluding that Louisiana's AWP statute, § 2202(5)(c) of the State's Health Care Cost Control Act, which applied to "group purchasers," referred to ERISA qualified plans by defining "group purchasers" to include entities such as "'Taft-Hartley trusts or employers who establish or participate in self-funded trusts or programs' which 'contract [with health care providers] for the benefit of their . . . employees.'").

Although in the recent case of *Washington Physicians Service Association v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, *525* U.S. 1141, 119 S. Ct. 1033, 143 L. Ed. 2d 42 (1999), the court found that Washington's "every category of provider" statute did not contain a "reference to" or "connection with" employee benefit plans, the statute at issue is distinguishable from Kentucky's AWP laws. The court noted that by the statute's definition, "health carrier" only included disability insurers, health care service contractors, or health maintenance organizations. *See id.* at 1043. Employer-sponsored, self-funded plans were excluded not by a provision of the act, but rather by limiting the act's application to only the mentioned entities. As a result, the act contained no reference whatsoever to ERISA-covered employee benefit plans.

While a mere reference to an ERISA plan, without more, may not be enough to cause preemption, Supreme Court precedent shows that if such a reference is combined with some effect on those plans, such as singling them out for different treatment, preemption will result. *See, e.g., Mackey*, 486 U.S. at 830 n.4, 108 *S.* Ct. at 2186, 100 L. Ed. 2d at 844; cf. *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580, 121 L. Ed. 2d 513 (1992) (finding that a state law that imposes requirements merely by reference to ERISA is preempted).

We conclude that Kentucky's AWP statutes "relate to" ERISA plans and are therefore preempted, unless they are found to be statutes that regulate "insurance" under the savings clause of § 514(b)(2)(A). This conclusion also involves consideration of the "deemer" clause, § 514(b) (2)(B), which ensures that ERISA employee benefit plans are not deemed to be engaged in the business of insurance in applying the savings clause. Under the deemer clause, state insurance laws that apply directly to ERISA *self-insured* plans do not fall within the savings clause and thus are preempted. *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985); *FMC Corp. v. Holliday,* 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990).

The Kentucky legislature, aware of its inability to regulate self-insured ERISA plans, sought to include such plans - as well as multiple employer welfare arrangements (MEWAs) -only "to the extent permitted by ERISA." The effect of this provision is to exclude self-insured ERISA plans from coverage of the statute by virtue of the deemer clause and to include MEWAs only to the extent state regulation is permitted under 29 U.S.C. § 1144(B)(6).[7] In *Community Health Partners v. Commonwealth of Kentucky,* 14 F. Supp. 2d 991 (W.D. Ky. 1998), District Judge McKinley pointed this out in his opinion:

> The fact that the Kentucky legislature chose to allow for regulation of MEWAs and self-insured plans "to the extent permitted by ERISA" suggests that the legislature was well aware of the preemptive force of ERISA. As noted by Defendant, the phrase appears merely to restate the "deemer clause" by exempting self-insured ERISA plans from the scope of the AWP statute. The "deemer clause" prevents a state law

[7] 29 U.S.C. § 1144(B)(6) permits state laws that regulate insurance to apply to MEWAs under the circumstances set forth in that section.

> from "deeming" an employee benefit plan to be an insurance company for the purpose of any law purporting to regulate the business of insurance. 29 U.S.C. 1144 (b)(2)(B). The deemer clause thus effectively prevents states from subjecting self-insured plans to state insurance regulation. On the other hand, insured plans - plans that purchase insurance - are subject to state laws regulating the insurance industry. *See Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 732, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985).

Id. at 995 n.4.

As the Supreme Court noted in *UNUM Life Insurance Co. v. Ward, 526 U.S.* 358, 367 n.2, 119 S. Ct. 1380, 1386, 143 L. Ed. 2d 462, 472 (1999):

> Self-insured ERISA plans ... are generally sheltered from state insurance regulation.

The Kentucky Act provides that shelter by its exclusion of ERISA self-insured plans from its coverage, but its reference to ERISA plans and its exclusion of self-insured ERISA plans from its coverage clearly bring the statute within the "refer to" prong of the "relate to" analysis.

B. Connection With

While the fact that the Kentucky statutes "refer to" ERISA employee benefit plans is enough to potentially preempt them on that basis alone, their "connection with" such plans offers an alternative basis for such preemption. Analysis under the "connection with" prong has changed somewhat after the Supreme Court's opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695

(1995).[8] The *Travelers* Court discussed whether ERISA's preemption provision altered the starting presumption that Congress does not intend to supplant state law. *See id.* at 654-55, 115 S. Ct. at 1676-77, 131 L. Ed. 2d at 704. While observing that this presumption remained unaltered, the Court recognized that its prior attempts to construe "relate to" did not provide much help drawing the line as to what should be preempted. *See id.* at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705. The Court concluded that in order to determine whether the normal presumption against preemption has been overcome in a particular case, it "must go beyond the unhelpful text and the frustrating difficulty of defining [§ 514 (a)'s] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705. The Court found that the "basic thrust" of the clause was "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," and observed that under its past case law it had found ERISA to preempt state laws that mandated employee benefit structures or their administration. *Id.* at 657-58, 115 S. Ct. at 1677-78, 131 L. Ed. 2d at 706. The use of this approach for "connection with" analysis was subsequently endorsed and used by the Court both in *Dillingham* and *De Buono* and recognized by this circuit in *Davies v. Centennial Life Insurance Co.*, 128 F.3d 934 (6th Cir.

[8] In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 117 S. Ct. 1747, 138 L. Ed. 2d 21(1997), the Court explained its change in focus, stating that its earlier ERISA cases had not required a fine analysis of the scope of ERISA's "relate to" language, because the state laws at issue had a clear "connection with or reference to" ERISA benefit plans. *De Buono*, 520 U.S. at 813, 117 S. Ct. at 1751, 138 L. Ed. 2d at 28-29. The Court explained that in *Travelers*, however, it was forced to confront directly whether ERISA's "relates to" language altered the normal starting presumption that Congress does not intend to supplant state law. *See id.*

1997).[9]

Using the *Travelers* "connection with" analysis, the district court in the case at bar determined that Kentucky's AWP laws had a connection with ERISA plans. The court found that while the law did not operate directly on ERISA plans, it effectively required benefit plans to purchase benefits of a certain structure, thereby bearing indirectly but substantially on all insured plans. As a result, the court concluded that the AWP statutes did more than just indirectly affect the cost of ERISA plans; the AWP statutes mandated benefit structures.

Two other district courts in Kentucky recently drew the same conclusion while addressing the same statute. In *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991, 1000-01 (W.D. Ky. 1998), the court found Kentucky's AWP provision, located then at § 304.17A-110(3), to be similar in effect to the mandated benefit law in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985). In *Metropolitan*, the Supreme Court held that the Massachusetts mandated benefit law "related to" ERISA plans because the statute bore indirectly, but substantially, on all insured employee benefit plans by effectively requiring the plans to purchase mental health benefits when purchasing a certain kind of common insurance policy. *See id.* at 739, 105 S. Ct. at 2388, 85 L. Ed. 2d at 740. Similarly, the *Community Health Partners* court believed that the AWP law effectively mandated the benefit structure of ERISA plans and regulated the relationship between traditional ERISA entities, *i.e.*, the plan, the employer, and the plan fiduciaries and beneficiaries. 14 F. Supp. 2d at 997.

[9] In changing its "relate to" analysis in *Travelers*, the Court appears to have been addressing only the "connection with" prong, as its statements in later cases indicate the "reference to" prong was unaffected. *See De Buono*, 520 U.S. at 815 n.15, 117 S. Ct. at 1752, 138 L. Ed. 2d at 30; *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799.

A recent memorandum opinion, *Ward v. Alternative Health Delivery Systems, Inc.*, 55 F. Supp. 2d 694 (W.D. Ky. 1999), held that § 304.17A-171, which contains regulations of a health benefit plan's use of chiropractic services, including an AWP provision, was preempted by ERISA due to its connection with employee benefit plans. *Id.* at 701. The judge found that:

> By specifically prohibiting health organizations from offering networks with limited chiropractic providers, the statute mandates the plan's structure. Moreover, the statute also dictates that all covered participants shall have access to the chiropractor of their choice. This too dictates a certain structure to which an employer's health care plan must succumb. As such this claim also falls within the realm of ERISA preemption.

Id. at 699.

Some academic literature has suggested that the Supreme Court's post-*Travelers* case law may represent a "sea change" in the "relation to" analysis; however, neither the Court's nor the circuits' opinions yet confirm this assertion.[10] The two appellate courts that have addressed the issue since *Travelers* both found that the AWP statutes at issue were "connected with" ERISA covered employee benefit plans. *See CIGNA Healthplan of La., Inc. v. Louisiana,* 82 F.3d 642, 648-49 (5th Cir. 1996); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.* 105 F.3d 1035, 1037 (5th Cir. 1997). In both of these cases, the courts recognized that under the reasoning of *Travelers,* state laws that mandate employee

[10] While Justice Scalia has suggested that the Court should really be applying field preemption, rather than the express preemption test it has created for analyzing ERISA's preemption provisions, *Dillingham*, 519 U.S. at 335-36, 117 S. Ct. at 843, 136 L. Ed. 2d at 806 (1997) (Scalia, J., concurring), absent further direction from the whole Court on this issue we must continue to apply the traditional analysis.

benefit structures are preempted. Finding the AWP statutes at issue did exactly that, both courts concluded that they were trumped by ERISA's preemption provision. *Cf. Stuart Circle Hosp. Corp. v. Aetna Health Management,* 995 F.2d 500, 502 (4th Cir. 1993) (finding, in a case prior to *Travelers,* that Virginia's AWP statute related to ERISA covered employee benefit plans because it eliminated an insurer's ability to choose limited provider networks).

We are convinced that even after the change of emphasis worked by *Travelers* on the "connection with" prong of the Supreme Court's "relation to" preemption analysis, the district court in this case was correct in finding that former § 304.17A-110(3) (now § 304.17A-270) and present § 304.17A-171 were both "connected with" ERISA covered plans. They not only affect the benefits available by increasing the potential providers, they directly affect the administration of the plans.

The Kentucky statutes in question meet both prongs of the "relation to" analysis and thus are preempted, unless found to be statutes that regulate insurance under the savings clause of § 514(b) (2)(A).

III. Insurance Savings Clause

Having concluded that Kentucky's AVWP laws relate to ERISA covered employee benefit plans, and are thus within the scope of ERISA's preemption provision, the Court must then determine whether the laws fall within ERISA's savings clause. The savings clause states that, "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This provision provides a broad and important exception to ERISA's preemption provision, saving state laws that relate to ERISA plans from preemption so long as they "regulate insurance." Much like the preemption provision itself, however, the

scope of the savings clause has proved difficult to determine from its sparse language.[11]

The Supreme Court has endeavored to provide guidance on what it means to "regulate insurance," first addressing the issue in *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985), and most recently describing the test in *UNUM Life Insurance of America v. Ward,* 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999), stating:

> Our precedent provides a framework for resolving whether a state law "regulates insurance" within the meaning of the saving clause. First we ask whether, from a "common sense view of the matter," the contested prescription regulates insurance. Second, we consider three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." (internal citations omitted).

Ward, 526 U.S. at 367-68, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472.

The Court noted that the three McCarran-Ferguson factors are "considerations [to be] weighed' in determining whether a state law regulates insurance" and that "[n]one of these criteria is necessarily determinative in itself." *See id.* at 373, 119 S. Ct. at 1389, 143 L. Ed. 2d at 476. Therefore, in determining whether Kentucky's AWP laws are saved from preemption by ERISA § 514(b)(2)(A), one must first ask whether as a matter of common sense they regulate insurance, and then look to the McCarran-Ferguson factors as checking points or guideposts to aid the analysis.

In *Ward,* the Court was faced with the question of whether California's notice-prejudice rule[12] was preempted by ERISA. The parties had agreed that California's notice-prejudice rule "related to" ERISA covered plans under § 514(a), so the Court had only to determine whether the rule was saved by the insurance regulation savings clause of § 514(b)(2)(A). 526 U.S. at 367, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472. The Court began with the common sense prong of its insurance regulation savings clause test, observing that:

> The California notice-prejudice rule controls the terms of the insurance relationship by "requiring the "insurer" to prove prejudice before enforcing proof-of-claim requirements." *Cisneros,* 134 F.3d at 945. As the Ninth Circuit observed, the rule, by its very terms, "is directed specifically at the insurance industry and is applicable only to insurance con-

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[11] *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728, 740 (1985), in which the Court stated:

> [T]he sphere in which § 514(a) operates was explicitly limited by § 514(b)(2). The insurance savings clause preserves any state law "which regulates insurance, banking, or securities." The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.

[12] The rule states, "a defense based on an insured's failure to give timely notice [of a claim] requires the insurer to prove that it suffered actual prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice." *Ward*, 526 U.S. at 366-67, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472.

tracts." *Ibid.;* see Brief for United States as Amicus Curiae 12 ("[O]ur survey of California law reveals no cases where the state courts apply the notice-prejudice rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms of prejudice to an 'insurer' resulting from untimeliness of notice."). The rule thus appears to satisfy the common-sense view as a regulation that homes in on the insurance industry and does "not just have an impact on [that] industry." *Pilot Life*, 481 U.S. at 50, 107 S. Ct. 1549.

Ward, 526 U.S. at 368, 119 S. Ct. at 1386-87, 143 L. Ed. 2d at 472-73.

Ward makes it clear that the most important aspect of the test is whether from a common sense view of the matter the contested statute regulates insurance. The three McCarran-Ferguson factors are of secondary importance, serving only as "checking points" or "guideposts" and not as essential elements. Indeed, in *Ward,* the Court ignored the first McCarran-Ferguson factor altogether in its analysis of the challenged statute in that case.

The Kentucky Act meets the common sense test in that it clearly does regulate insurance, The fact that it includes within its reach HMOs as well as traditional insurance companies does not take it out of the realm of insurance regulation. We agree with the reasoning of the Ninth Circuit in *Washington Physicians Service Association v. Gregoire,* 147 F.3d 1039 (9th Cir. 1998), in which the Court said:

> The Washington law is "specifically directed" toward the insurance industry, *Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549, because it operates directly on HMOs and HCSCs, entities that are engaged in the business of health insurance. "The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Group Life & Health Ins. Co. v. Royal Drug Co.,* 440 U.S. 205, 211, 99 S.Ct. 1067, 59 L. Ed.2d 261 (1979), citing 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed.1959)("It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it."). The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, *Anderson v. Humana, Inc.,* 24 F.3d 889, 890 (7th Cir. 1994), but this is a distinction without a difference. *Metropolitan Life,* 471 U.S. at 741,105 S. Ct. 2380 (explaining that nothing in ERISA "purports to distinguish between traditional and innovative insurance laws"); *Klamath-Lake Pharmaceutical Ass'n v. Klamath Med. Serv. Bureau,* 701 F.2d 1276, 1286-87 (9th Cir. 1983). In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

Id. at 1045-46.[13] In *Anderson v. Humana, Inc.,* 24 F.3d 889, 892 (7th Cir. 1994), the court said: "Because HMOs spread risk - both across patients and over time for any given person - they are insurance vehicles under Illinois law." They are likewise "insurance vehicles" under Kentucky law.

It is true that the statutes would reach certain self-insured health care benefit plans that are not under ERISA's protective "deemer" clause, *e.g.,* self-insured government plans and

[13] As noted earlier, the Ninth Circuit in *Gregoire* found that the Washington statute did not come within the scope of ERISA's pre-emption clause. Nevertheless, the Court found that, even if it did, the statute dealt with the regulation of insurance and would therefore be saved from pre-emption.

self-insured church plans, because they are excluded entirely from ERISA's coverage under 29 U.S.C. § 1003(b). We do not see this fact, however, as any barrier to a finding that a common sense view is that the statutes regulate insurance. We know of no reason why it is not within the authority of a state in enacting laws dealing with insurance to include within such laws entities that act as self-insurers as well as entities who purchase insurance. As the author of a well-known treatise has said, "Self-insurance has often led courts and legislatures to struggle with the intriguing question of whether a party who has not purchased insurance, effectively acting as its own insurer, should be the equivalent of an insurer." 1 COUCH ON INSURANCE 3d § 10.2. It is pointed out that this difficulty in modern practice is frequently removed by express statutory provisions specifying that a particular requirement does or does not apply to self-insured entities. *Id.* Kentucky has done this by expressly including self insurers to the extent permitted by ERISA - within the coverage of the statutes in question.

The state's regulation of health benefit plans is set forth in Kentucky's Insurance Code (Chapter 304 of Title XXV dealing with Business and Financial Institutions). Subtitle 17A of the Insurance Code deals with health insurers and health benefit plans. Section 304.17A-005 contains the definition of words used in that subtitle. Paragraph 22 provides:

> "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

"Health benefit plan" is also defined, the relevant portion of

that definition tracking the above definition of "insurer:"

> "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; . . .

Ky. Rev. Stat. Ann. § 304.17A-005(17).

The AWP provision of Kentucky's Insurance Code specifically is directed at "insurers" by providing that:

> A *health insurer* shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky State Medicaid program and Medicaid partnerships (emphasis added).

Ky. Rev. Stat. Ann. § 304.17A-270.

The chiropractic AWP provision specifically adopts the definition of a health benefit plan as set forth in Kentucky Revised Statutes Annotated § 304.17A-005 and defines "health care insurer" as any entity "authorized by the state of Kentucky to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of similar nature which indemnify or compensate health care providers for the provision of health care services." Ky. Rev. Stat. Ann. § 304.17A-170(7).

The Kentucky AWP laws are thus specifically directed toward "insurers" and the insurance industry and are ones that from a "common sense view" regulate insurance.

The fact that the deemer clause prevents ERISA self-

insured plans from being considered as engaging in the business of insurance does not mean that self-insured plans, by their nature, do not involve the business of insurance and are beyond the reach of state regulations dealing with insurance. The distinction between plans funded by the purchase of insurance and plans that are funded by employers as self-insured plans results from "a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. at 747, 105 S. Ct. at 2393, 85 L. Ed. 2d at 745. It is not a distinction based upon a concept that employers who choose to be self-insurers cannot be considered insurers subject to state regulations dealing with insurance. Therefore, the fact that the Kentucky statute reaches self-insurers who are not protected by ERISA's deemer clause does not detract from its characterization as a statute regulating entities engaged in the business of health insurance.

As noted earlier, the Kentucky statutes exclude from their scope self-insured ERISA plans. If such a plan provides for a limited group of providers, the AWP laws would not compel a change in that plan, regardless of the nature of the entity administering the plan. It could not be enforced, in our opinion, against the employer who has a self-insured ERISA plan nor against the administrator of such a plan, even if the administrator is an entity, such as an HMO, which would be subject to the statute if it were acting not as a mere administrator but as an insurer of its own plan. In *Light v. Blue Cross and Blue Shield*, 790 F.2d 1247 (5th Cir.1986), the court rejected the argument that a state law could be enforced against the administrator of a self-insured ERISA plan because the deemer clause, § 514(b)(2)(B), which protects such plans from state regulation, does not expressly include plan administrators among the exempted entities. The court found the fact that administrators of self-insured plans are not mentioned in the deemer clause to be of no significance, and be-

cause the state law was preempted, the claim against the administrator of the plan based on that law could not be brought, even though the plan itself provided that the contracts between the employer and the plan administrator would "conform to applicable state laws." The court observed that, "If ERISA preempts state law, there is no applicable state law to which the administrator must conform." *Id.* at 1248.

In *Prudential Insurance Company of America v. National Park Medical Center, Inc.,* 154 F.3d 812 (8th Cir. 1998), the court found that an Arkansas statute that contained an AWP provision did not meet the common sense test because, in part, its scope included "employers and administrators of self-insured plans" (although the statute excluded ERISA self-funded plans). As noted above, however, we do not believe that inclusion of self-insurers not protected by the deemer clause, as well as purchasers of insurance, within the statute's reach in itself removes the statute from being viewed a permissible regulation of insurance based upon "a common understanding of insurance regulation." Also, unlike the Arkansas statute, the Kentucky statutes do not include "administrators of self-insured plans." They are di-

rected towards and limited to health care "insurers."[14]

Texas Pharmacy Association v. Prudential Insurance Company ofAmerica,105 F.3d 1035 (5th Cir.1997), contains the statement that if a self-insured employer, not subject to the any willing provider statute, "signed up with an HMO or

[14] The dissent contends that Kentucky's AWP provisions apply to third parties that a self-insured ERISA plan hires to administer its plan benefits. This contention, however, is based upon the dissent's reading of the repealed Kentucky statutes which prohibited "health care benefit plans" from discrimination and defined health benefit plans as including a health service corporation contract and a health maintenance organization contract. The present Kentucky statutes eliminate any ambiguity as to whether administrators under contracts with benefit plans are included within the scope of the statutes. They obviously are not. The current Kentucky statute prohibits *only* "a health *insurer*" from discrimination. Ky. Rev. Stat. Ann. § 304.17A-270. As the defendant correctly notes, "the new statute refers to health insurers which shall not discriminate among providers rather than health care benefit plans which strengthens Appellee's arguments that the AWP law regulates insurance." Brief of Defendant-Appellee, p. 3 n.5. An entity that merely administers a plan for a health insurer and does not participate in the underwriting of the risk is not an "insurer" and is not within the scope of Kentucky's current statutes which are, by their express terms, directed solely at health *insurers*. This is acknowledged by the defendant:

> The statutes establish that health insurers, which assume financial risk, cannot discriminate against qualified providers. Therefore, although the statute tenuously affects the relationship between insurers and providers, its focus is on the contractual relationship between the insurer and the insured.

Brief of Defendant-Appellee, p. 18.

Thus, under the current AWP statute, the insurer of a plan, including a self-insurer of a non-ERISA benefit plan, must not discriminate against qualified providers, and any health benefit plan of such insurer must conform to the statute. While not included as an entity subject to the statute, a plan administrator would necessarily be required to comply with the plan's non-discriminatory requirement. With respect to self-insured ERISA benefit plans, the insurer of such plans is beyond the scope of the statute by its express terms, and the administrators of such plans who act solely as administrators and not as insurers are likewise beyond the scope of the statute because of its application only to health insurers.

PPO, those organizations would be subject to the statute, even if there is no insurance company involved." *Id.* at 1039. The court was presumably referring to the HMO or PPO acting as the administrator of the employer's self-funded plan. We believe, however, that, as the court in *Light* observed, if ERISA preempts the state law with respect to self-funded plans, there is no state law to which the administrator of the self-funded plan must conform. Furthermore, as previously noted, the Kentucky statute is directed toward and applies to only insurers and not to plan administrators. *Supra*, note 14. A plan administrator that does nothing more than administer the plan of a self-insured employer is not engaged in "the underwriting and spreading of risk," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221, 99 S. Ct. 1067, 1077, 59 L. Ed. 2d 261, 274 (1979), and in our view, would not be considered an "insurer" of a health benefit plan as that term is used in Kentucky's AWP laws.[15]

[15] The dissent believes that the majority is "apparently saying that the law is clearly preempted and not saved insofar as it applies to plan administrators, and then arguing that due to this preemption, the statute does not apply to entities outside the insurance industry." According to the dissent, this is an "attempt to dissect Kentucky's AWP provisions, dismissing some of the provision's applications as preempted and then applying saving clause analysis only to those applications it wishes to retain." This is a misreading of the majority opinion. The majority does not say that the Kentucky statutes are preempted insofar as plan administrators are concerned. The majority is saying that insofar as self-insured ERISA plans are concerned, the Kentucky AWP laws could not be enforced against a plan administrator, as a matter of law, under the reasoning of *Light*, because if the law is preempted with respect to self-insured plans, "there is no applicable state law to which the administrator must conform." More importantly, however, is the fact that the present Kentucky AWP statute, Ky. Rev. Stat. Ann. § 304.17A-270, prohibits only health *insurers* from discrimination and would have no application to an entity acting merely as an administrator of an insurer's plan. Although the chiropractic statute still refers to a prohibition against "health benefit plans" discrimination, Ky. Rev. Stat. Ann. § 304.17A-171(2), the majority believes that, properly construed, this encompasses insurers of health benefit plans and not mere administrators of such plans.

In *Metropolitan Life*, 471 U.S. at 743-44, 105 S. Ct. at 2391, 85 L. Ed. 2d at 743, the Supreme Court said:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement - these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S. Ct. 564, 568, 21 L. Ed. 2d 668 (1969).

The Kentucky AWP laws deal directly with the relationship between insurers and insureds under health benefit plans. They affect restrictions by the insurers on the number of health care providers available to the insureds under such plans; they increase benefits to the insureds by giving them greater freedom to choose health care providers under the plans; and they are aimed at regulating this insurance relationship. They are part of a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans, and they are, in our view, clearly laws which, in a common sense view of the matter, "regulate insurance" and thus are saved from preemption.

Consideration of the three McCarran-Ferguson factors used in the second step of the analysis as "checking points" or "guideposts" does not require a different result. First, although certainly a debatable issue, we agree with the reasoning of the Fourth Circuit in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), that the first factor - "transferring or spreading the policyholder's risk" - is satisfied:

> There are several components to the "policyholder's risk." They include the types of illness and injury that the insurance contract covers, provision for treatment, and the cost of treatment. The Virginia statute affects the type and cost of treatment available to an insured. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

Id. at 503.

Plaintiffs point out that the Kentucky statutes in question do not require health benefit plans to contract with any additional provider, but only with providers who are willing to meet the network's terms and conditions. While this is unquestionably true, it does not, in our view, change the fact that the statutes open an otherwise closed door, insofar as the availability of health care providers is concerned. Some may choose to go through that door and join the group of providers while others may not, but this does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds. It effectively changes the terms of the policy, admittedly not in terms of covered medical condition but in terms of covered treatment by health

care providers.[16]

While Plaintiffs understandably rely on *Group Life & Health Ins. Co. v. Royal Drug* Co., 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979), in support of their position that the first factor is not present in this case, we believe *Royal Drug* does not require that conclusion. Unlike the health plans that are the subject of the Kentucky statutes, the insurer in *Royal Drug* did not restrict the number of providers in question. Blue Cross had offered to enter into a provider agreement with every licensed pharmacy in Texas. The benefit conferred on the insureds by the Kentucky AWP statutes - removal of restrictions on the number of providers - was already present in *Royal Drug*. The Supreme Court expressly noted, with reference to its discussion of contracts between the insurer and providers, "[t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the 'business of insurance' within the meaning of the [McCarran-Ferguson] Act." *Id.* at 230 n.37, 99 S. Ct. at 1082, 59 L. Ed. 2d at 279. Unlike Royal *Drug*, policyholders in Kentucky will benefit under their policies by a new change in coverage, insofar as availability

[16] The dissent characterizes this conclusion as "mysterious." There is no mystery, however, in the undeniable fact that there is a difference between a closed network of providers chosen by the insurer and an open network of providers consisting of all providers - including providers preferred by the insured patients - who are willing to agree to the same terms as the other network providers. It is an extremely significant difference and one which not only changes the conditions of the plan but, by opening an otherwise closed door, expands the potential for inclusion of additional equally competent medical providers. It is in this sense that the AWP laws change "the terms of covered treatment by health care providers."

of providers is concerned.[17]

The policyholders in *Royal Drug* were "basically unconcerned with arrangements made between Blue Shield and participating pharmacies." *Id.* at 214, 99 S. Ct. at 1074, 59 L. Ed. 2d at 270. They paid a fixed price ($2.00) to a participating pharmacy for each prescription, and consequently they were not concerned with Blue Shield's cost for those prescriptions. Similarly, the policyholders in Kentucky are basically unconcerned with arrangements made between the insurers and participating providers regarding the insurers' cost for the medical services obtained by the insurers. The Kentucky statutes do not seek to change the terms and conditions of those cost arrangements. They merely require that any provider who is willing to meet the same terms and conditions of those arrangements should be allowed to join the list of participating providers. While Kentucky policyholders may be basically unconcerned with the insurers' compensation arrangements with participating providers, it cannot be said that they are unconcerned with a limitation on the number of such providers and the resulting restriction on their

[17] In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), the court, in considering a Massachusetts AWP statute, distinguished Royal Drug on the ground that, "[b]y directing insurers to open their networks, the Act should affect the availability of benefits to insureds by increasing their ability to select pharmacies of their choice. This does concern the relationship between insurer and policyholder, and thus may be considered part of the business of insurance." *Id.* at 71-72.

freedom of choice in seeking medical treatment.[18]

The Fifth Circuit has also distinguished *Royal Drug* in its discussion of a prior Texas AWP statute pertaining to pharmacies in *Texas Pharmacy Association v. Prudential Insurance Co. of America,* 105 F.3d 1035 (5th Cir. 1997), agreeing with the reasoning of the Fourth Circuit in *Stuart Circle Hospital Corp.* "Unlike the third-party pharmacy agreements in *Royal Drug,* the prior Texas statute directly regulated the terms of the insurance policy between the insurer and the insured." *Id.* at 1041.

Finally, it should be emphasized, in applying the McCarran-Ferguson factors, that "the focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders," and state statutes aimed at regulating that relationship, "directly or indirectly, are laws regulating the 'business of insurance." *United States Dep't of the Treasury v. Fabe,* 508 U.S. 491, 501, 113 S. Ct. 2202, 2208, 124 L. Ed. 2d 449, 459 (1993). In *Fabe,* the Court held that, "[t]here can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as

[18] The dissent states that, "It is true that the AWP laws would likely force insurers to pay higher rates." The economic effect of the AWP laws in question, however, is speculative at best. As one commentator has noted, "While AWP legislation could remove some of the incentive for health care providers to substantially discount their fees, provider reaction will most likely differ according to the number of MCOs (managed care organizations) and providers present in each market." James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Andy Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 210 (1996-1997). The same author reports that, insofar as any increase in consumer cost is concerned, there is some evidence that health care costs have not risen in those states that have enacted AWP legislation. *Id.* at 212. The possible economic effect on insurers must be weighed against "... the fact that managed care threatens Americans' right to freely choose their provider, and AWP legislation protects that right." *Id.* at 217-218. In any event, the decision of the Kentucky legislature to enact AWP laws is one left to the wisdom of that deliberative body, and the possible economic ramifications of its AWP laws should not concern this court.

we understood that phrase in *Pireno* and *Royal Drug.*" *Id.* at 503, 113 S. Ct. at 2209, 124 L. Ed. 2d at 461. Furthermore, in *Fabe,* the Court distinguished *Royal Drug* on the ground that it was an antitrust law case, and the Court in that case was construing the words, "the business of insurance" contained in the second clause of § 2(b) of the McCarran-Ferguson Act, the antitrust law exemption *(see* 15 U.S.C. § 1012(b)).[19] The first clause, which commits laws "enacted by any State for the purpose of regulating the business of insurance" to the States is, according to the Supreme Court, "not so narrowly circumscribed." *Id.* at 504, 113 S. Ct. at 2209, 124 L. Ed. 2d at 461.

The second McCarran-Ferguson factor is, in our view, unquestionably present in this case. The ability of an insured to select a physician of his or her choice to treat a medical condition covered by the insurance is an integral part of the policy relationship between the insurer and the insured. In *Ward,* the Supreme Court dealt with a state law which required an insurer to show that it was prejudiced by an untimely proof of claim before it could avoid liability. The Court, as noted earlier, did not even pursue the issue of whether the statute satisfied the first factor - the risk alteration factor - because the other two factors verified the common sense view of the statute as one regulating insurance. The Court specifically rejected the argument that the statute was not such a law because it did not change any substantive terms of the insurance coverage.

> We reject UNUM's suggestion that because the notice-prejudice rule regulates only the administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See Metropolitan Life,* 471 U.S. at 728 n.2, 105 S.Ct. 2380

[19] The Court in Royal Drug said, "It is well settled that exemptions from the antitrust laws are to be narrowly construed." 400 U.S. at 231, 99 S. Ct. at 1083, 59 L. Ed. 2d at 280.

> (including laws regulating claims practices and requiring grace periods in catalogue of state laws that regulate insurance).

526 U.S. at 375 n.5, 119 S. Ct. at 1390, 143 L. Ed. 2d at 477.

In Plaintiffs' view, the second factor is not satisfied because the AWP provisions leave the contract terms between the insurer and the insured unaltered, the medical risks remain the same, and even if an insured's provider decides to join the insured's network, the medical coverage remains the same. While it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage, it is not necessary that the statutes do this before they can be found to be statutes regulating insurance. *Id.* Kentucky's AWP laws do, however, directly impact the insurer-insured relationship because they affect restrictions on the network of providers available for treatment under the plan and they directly affect the administration of the plan. As in *Ward*, the statutes effectively create a mandatory contract term dealing with the manner in which the plan is administered by expanding covered treatment from a closed pool of providers to an open pool of providers. As the Fourth Circuit said in *Stuart Circle Hospital Corp.*, 995 F.2d at 503, "We repeat, treatment and cost are important components of health insurance. Regulations governing these components, such as the Virginia statute, are integral parts of the relationship between insurer and insured." In our view, the second McCarran-Ferguson factor is clearly satisfied.

We also conclude that the third factor - the statute's limitations to entities within the insurance industry - is satisfied. For reasons stated earlier, we believe that entities such as HMOs and self-insurers are engaged in the business of insurance along with the more widely recognized and more traditional commercial insurance companies, and that entities acting solely as plan administrators and not as "health insurers" are not within the scope of the statute. As District Judge

McKinley pointed out in *Community Health Partners:*

> Whatever difference in form or structure that exists as between traditional insurance companies and HMOs, MEWAs, and provider-sponsored integrated health delivery networks is insufficient to establish that Kentucky's AWP law is not limited to entities within the insurance industry. To hold otherwise would require the Court to recognize form over substance and to refuse to recognize the natural evolution of the health insurance industry. *Cf. SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 71, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959) (We realize that life insurance is an evolving institution. Common knowledge tells us that the forms have greatly changed even in a generation. And we would not undertake to freeze the concepts of "insurance". . . into the mold they fitted when these Federal Acts were passed.)

14 F. Supp. 2d at 1003-04.[20]

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[20] In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), a Massachusetts AWP statute, unlike the Kentucky AWP laws, did not exclude ERISA self-insured plans from its coverage. Because such plans are not insurers under the "deemer" clause, the argument was made that the state statute was not directed specifically toward the insurance industry. In rejecting this argument, the court noted that, with reference to ERISA self-insured plans, "any decision holding that the Act is saved from preemption by the insurance saving clause would have to recognize that the Act could not apply to the provision of services to self-insured plans. Because the Act would not apply to these uninsured relationships, it is unnecessary to consider whether the Act would lose its status as an insurance regulation because it purports to cover these relationships." *Id.* at 71 n.9. The court also pointed out that in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985), the fact that the state statute "applied by its terms to self-insured plans did not prevent the Supreme Court from concluding that the statute was limited to the insurance industry. Instead, the deemer clause simply prevented application of the statute to self-insured plans." *Id.* (internal citations omitted).

It must be reiterated and emphasized that the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance. They are, as the Supreme Court pointed out in *Ward*, nothing more than "checking points" or "guideposts." The basic test is whether, from a common sense view, the Kentucky AWP laws in question regulate insurance. We conclude, as did the two Kentucky District Judges who carefully considered this question, that they do.

IV. Conclusion

With respect to Kentucky's AWP statute, Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999), and Kentucky's chiropractic AWP statute, Kentucky Revised Statutes Annotated § 304.17A-171(2) (Banks-Baldwin 1999), the judgment of the district court is affirmed. Because the district court opinion does not discuss the additional requirements imposed by provisions (1) and (3)(8) of § 304.17A-171, dealing with chiropractors and health benefit plans, this case is remanded to the district court for consideration in the first instance of the issue of their preemption by ERISA.[21]

[21] Having concluded that Kentucky's AWP statutes are valid, there is no reason for the majority opinion to discuss any question of severability. The dissent, however, in discussing the question of severability, states that the majority "fails to mention, let alone discuss, how it severs Kentucky's AWP provision in such a manner that it no longer applies to third party plan administrators performing administrative functions for self-insured plans, thereby allowing it to conclude that the provision is saved in all other applications." As noted earlier, *supra*, note 15, this is a misreading of the majority opinion. The majority does not hold that the AWP statutes are preempted as applied to administrators of ERISA self-insured plans. It holds, instead, that because the statutes exclude ERISA self-insured plans, they could not be applied against an administrator of such plans under the reasoning of *Light* and, more importantly, they prohibit only health *insurers* from discrimination and, therefore, exclude entities that act solely as administrators of the insurer's health benefit plan.

DISSENT

KENNEDY, Circuit Judge, dissenting. I write separately with respect to Part III of the majority's opinion to dissent from the majority's conclusion that Ky. Rev. Stat. Ann. §§ 304.17A-270[1] and 304.17A-171(2) (Banks-Baldwin 1995) fall within ERISA's insurance savings clause. I believe that Kentucky's any willing provider laws have little to do with insurance and are not saved from preemption by ERISA's Insurance Savings Clause as they do not regulate insurance as a matter of common sense and fail all three of the McCarran-Ferguson factors.

I. Insurance Savings Clause

A.

The district court in the case at bar devoted only a sentence to the common sense test, merely concluding that, "the common-sense view is that the AWP statutes regulate the business of insurance."[2] Instead the court spent most of its time analyzing the McCarran-Ferguson factors, which significantly overlap the common sense test, being designed

[1] As noted in the majority's opinion, § 304.17A-110(3) was the provision that was actually before the district court. However, both the parties have agreed that this appeal will govern § 304.17A-270 as well, as it is essentially a remodification of § 304.17A-110(3). Accordingly, unless otherwise noted I would apply my analysis of § 304.17A-110(3) to § 304.17A-270 as well.

[2] The district court in the companion case of *Community Health Partners, Inc. v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991 (1998) devoted more room to its discussion of the common sense test. The court concluded that the statute satisfied the common sense test because it affected specific terms of the insurance policy, was located in the insurance code and regulated insurers or insurer related entities. *Id.* at 1001-02. While the district court conducted a careful analysis, I reach a contrary conclusion on all points for the reasons explained below.

largely to guide a court's common sense determination. *See Unum Life Ins. of Am. v. Ward,* 119 S. Ct. 1380, 1389 143 L. Ed. 2d 462 (1999).

As the Supreme Court has generally started its savings clause analysis with the common sense test, I begin there as well. *See id.* at 1386; *See also Davies* 128 F.3d 940-941 (6th Cir. 1997). In doing so, I conclude that the Kentucky AWP laws do not meet the common sense test because they are directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 50, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987) (concluding that to fall within the savings clause a law must be *specifically* directed at the insurance industry, which in part requires that the law define the terms of the relationship between the insurer and the insured, rather than the insurer and a third party). The laws do not change the relationship between the insurer and insureds, as the same medical conditions are covered after the AWP laws as were insured before the passage of these provisions. The underwriting of risk, the traditional earmark of insurance, *see Group Life & Health Ins. Co. v. Royal Drug Co.,* 440 U.S. 205, 211-12, 99 S. Ct. 1067, 1073-74, 59 L. Ed. 2d 261 (1979), is in no way affected. Insureds are not free to attend the provider of their choice, as the AWP laws merely require employee benefit plans to accept previously excluded doctors that are qualified, willing to join the plan, and agree to abide by its terms.

Contrary to the majority's assertions, I believe it is also apparent that Kentucky's AWP laws clearly target more than

just members of the insurance industry.[3] By their terms, Kentucky's AWP laws apply to non-ERISA covered self-insured plans by defining health benefit plans to include "a self-insured plan . . . to the extent permitted by ERISA." §§ 304.17A-100(4)(a) and 304.17A-170(1). This definition includes self-insured plans not regulated by ERISA, such as government plans and church plans, which ERISA excludes from its coverage. *See* 29 U.S.C. § 1003 (b). The result is that these self-insured plans, which, as a matter of common sense ought to be considered as operating outside the insurance industry, are subject to Kentucky's AWP laws. *Cf. Cigna Health Plan of La., Inc. v. Louisiana,* 82 F.3d 642, 649 (5th Cir. 1996) (concluding that the statute was not saved as an insurance regulation because it was not limited to entities in the insurance industry as it applied to entities such as self-funded organizations, Taft-Hartley Trusts, or employers who establish and participate in self-funded trusts or programs as well as various intermediaries); *Blue Cross & Blue Shield of Alabama v. Neilsen,* 917 F. Supp. 1532, 1538-39 (N.D. Ala. 1996) (holding that Alabama's AWP

[3] In addition to traditional insurance companies, Kentucky's AWP laws apply to entities such as HMO's and Health Service Corporations. These entities *might* be argued to fall within the insurance industry *if* they have agreed to accept the risk that the covered individual will need medical services in exchange for a fee. *See Group Life & Health Ins. v. Royal Drug,* 440 U.S. 205, 211, 99 S. Ct. 1067, 1073, 59 L. Ed. 2d 261 (1979) (stating that, "[t]he primary elements of an insurance contract are the spreading and underwriting of policyholder risk"). As such, they may be seen as underwriting policyholder risk and then covering that risk with the provision of medical services, rather than by paying for those services as a traditional insurer would. Given the somewhat subtle distinction in this difference, it could be argued that some HMO's and HSC's are engaged in the business of insurance. *See Washington Physicians Serv. Ass'n v. Gregoire,* 147 F.3d at 1045 (adopting this view); but *see Texas Pharmacy Ass'n,* 105 F.3d at 1038-39 (concluding that the Texas statute was not limited to entities within the insurance industry, as it applied to entities such as HMO's and PPO's). However, as Kentucky's AWP laws also apply to entities that are clearly outside the business of insurance, I believe that it is unnecessary for us to decide this issue.

statutes did not regulate insurance as a matter of common sense because they applied to all employee benefit plans, including self-funded plans, and were thus not specifically directed toward the insurance industry) (vacated in part on appeal by *Blue Cross & Blue Shield of Alabama v. Neilsen*, 142 F.3d 1375 (11th Cir. 1998) due to mootness after the Alabama Supreme Court determined in a certified question that the law at issue did not apply to plaintiff); *Stuart Circle*, 995 F.2d at 503-04 (concluding that the AWP statute at issue, which *only* applied to insurance companies actively issuing insurance policies, met the common sense test as a law regulating insurance).

Significantly, the AWP provisions also apply to third parties that a self-insured ERISA plan hires to administer its plan benefits. As used in §§ 304.17A-110(3) and 304.17A-171, "health benefit plan" also included Hospital, Health Service Corporation, and HMO contracts.[4] Section 304.17A-270 uses the term "Health Insurer" instead of "Health Benefit Plan," but similarly defines it to include any Insurance

[4] Section 304.17A-100(4)(a) defined "Health Benefit Plan" as including:

> Any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established by KRS 304.17A-160.

Ky. Rev. Stat. Ann. § 304.17A-100(4)(a). Section 304.17A-170 supplies a nearly identical definition of "Health Benefit Plan" (by reference to § 304.17A-005) for § 304.17A-171.

Company, HMO, or HSC.[5] Thus, Kentucky's AWP laws, by there very terms, prohibit *all* HMO's, HSC's and Insurance Companies from "discriminat[ing] against any provider who is located within the geographic coverage area of the health benefit plan . . . ." *See* §§ 304.17A-110(3) and 304.17A-171. The AWP laws would clearly apply to HMOs, HSCs, or Insurance Companies providing plan administration services, as there is nothing in the statute that would exclude them in such a scenario.

Although HMOs, HSCs, and Insurance Companies may accept risk in some situations, as third party administrators they would merely be contracting to handle paperwork and plan administration for a self-insured ERISA plan. While handling such administrative duties, however, these entities would be forced by Kentucky's AWP laws to accept any willing provider into the plan, even though they were not underwriting any risk. The law in this instance is not directed at the business of insurance, as no insurance is involved. *See*

[5] As observed in part I of the majority opinion, § 304.17A-270 recodified § 304.17A-110(3), merely substituting "Health Insurer" for "Health Benefit Plan," and leaving the AWP provision otherwise unchanged. Section 304.17A-005 defines "Insurer," as used in § 304.17A-270, as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider sponsored integrated health delivery network; self-insured employer organized association, or nonprofit hospital medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Ky. Rev. Stat. Ann. § 304.17A-005 (Banks-Baldwin 1999). This definition largely tracks repealed § 304.17A-100(4)(a)'s definition of "Health Benefit Plan." Despite the majority's claim that the substitution of the term "Health Insurer" for "Health Benefit Plan" in the current statute excludes administrators under contract with benefits plans from the scope of the statutes, the definition of "insurer" continues to include plan administrators.

Prudential Ins. Co., 154 F.3d at 829 (observing that the Arkansas AWP statute at issue defined health benefit plans so broadly as to include plan administrators and thus did not fit within a common sense view of a law directed specifically toward the insurance industry); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035, 1039 (5th Cir. 1997) (noting that a self-insured employer would not be subject to Texas' AWP statute, "but if the employer signed up with an HMO or PPO, those organizations would be subject to the statute, even if there is no insurance involved"); *Cigna Health Plan of La., Inc.* 82 F.3d at 649 (concluding that Louisiana's AWP law was obviously not limited to entities within the insurance industry, in part because it applied to "health care financiers, third party administrators, providers, or other intermediaries"). The only risk underwritten is that accepted by the ERISA self-insured plan, which under the "deemer clause" of ERISA § 514 (b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), cannot be treated as an insurance company for the purposes of state regulation. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S. Ct. 403, 409, 112 L. Ed. 2d 356 (1990); *Texas Pharmacy Ass'n*, 105 F.3d at 1039. The common sense conclusion that can be drawn from the AWP statute's coverage of entities clearly operating outside of the business of insurance is that the statute is concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance.[6] *See Prudential Ins. Co.*, 154 F.3d at 829 (concluding that the AWP law at issue was "not a law directed at the insurance industry at all, but a law directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry").

The majority seeks to refute this conclusion by arguing

[6] The fact that §§ 304.17A-110(3) and 304.17A-171(2) happen to be codified amongst Kentucky's insurance provisions does not alter this conclusion, as it in no way assures that the law is specifically directed toward the insurance industry.

that Kentucky's AWP law would not apply to entities performing only plan administration for self insurers, apparently on the grounds that to the extent that Kentucky's AWP law seeks to do so, they would be preempted by ERISA. In support the majority cites *Light v. Blue Cross and Blue Shield of Alabama, Inc.*, 790 F.2d 1247, 1248 (5th Cir.1986), which holds that state laws which apply to administrators of self insured plans may be preempted by ERISA and "if ERISA preempts state law, there is no applicable state law to which the administrator must conform." Other courts have drawn a similarly unremarkable conclusion. *See Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (concluding that Blue Cross and Blue Shield, which provided plan administration services for a self-insured employee benefit plan, were not engaged in the business of insurance and therefore that the state mandated benefit laws were preempted with respect to not only the underlying self-insured plan, but also the plan administrators).

Light, however, is inapposite to the proposition the majority ultimately seeks to advance, that is, if Kentucky's AWP law does not apply to self-insurers, *a fortiori*, it also does not apply to entities administering the self-insured plan. The employee benefit plan at issue in *Light* contained a provision stating that "the contracts between South Central Bell and the plan administrator necessarily will conform to applicable state laws." *Id.* at 465. Plaintiffs argued that since the plan adopted state law, the plan administrator was required to comply with that law. The Fifth Circuit began by noting that if ERISA preempted state law, there would be no state law for the administrator to conform to. The court then turned to Plaintiffs' argument that the preemption provision of 29 U.S.C. § 1144(a) should not be read to apply to plan administrators. Plaintiffs asserted that because their action was against a plan administrator, it did not relate to an employee benefit plan, and therefore was not preempted. The

court found no merit in plaintiffs' argument because, "[a]bsent ERISA the state common law on which [plaintiffs] rely would provide causes of action for the improper handling of claims under benefit plans," giving the law a "direct connection" with employee benefit plans. *Id.* at 1249. As a consequence, the court found § 1144 preempted plaintiffs' state causes of action with respect to the administrator of their self-insured plan as well. *Id.*

In the case at bar, the majority states that based in part on reliance on *Light,* it does not believe that Kentucky's AWP law could be enforced against plan administrators of self-insured plans. The majority appears to arrive at this conclusion due to its belief that, as in *Light,* Kentucky's AWP statute would be preempted insofar as it applies to plan administrators, given that Kentucky's AWP statute "relates to" employee benefit plans. However, having concluded that the *entire* AWP provision is preempted, the majority fails to apply savings clause analysis to the *entire* AWP provision. As I have discussed, Kentucky's law, by its very terms, does attempt to regulate entities outside the insurance industry, through its regulation of HMO and HSC and Insurance Company contracts, which would include contracts purely for plan administration. The majority attempts to ignore this fact by summarily concluding that the law would not apply to plan administrators. However, in doing so the majority is apparently saying that the law is clearly preempted and not saved insofar as it applies to plan administrators, and then arguing that due to this preemption, the statute does not apply to entities outside the insurance industry. The majority cites no authority for its attempt to dissect Kentucky's AWP provisions, dismissing some of the provision's applications as preempted and then applying saving clause analysis only to those applications it wishes to retain. In applying the common sense test we should be looking at the whole provision, not determining whether portions of a provision are saved in some, but not all scenarios.

In sum, unlike *Ward*, where the notice-prejudice rule was by its very terms "directed specifically at the insurance industry and [was] applicable only to insurance contracts," 119 S. Ct. at 1386, Kentucky's AWP laws clearly apply to entities and contracts outside the insurance industry.[7] As a result, I must conclude that §§ 304.17A-110(3) and 304.17A-171(2) do *not* "satisfy the commonsense view as . . . regulation[s] that hone in on the insurance industry" but rather the provisions "just have an impact on [that] industry." *See Ward*, 119 S. Ct. at 1387 (quoting *Pilot Life,* 481 U.S., at 50, 107 S.Ct. at 1554).

B.

Next I "consider [the] three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act: first whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is lim-

[7] In an attempt to dismiss the problem of partial preemption (insofar as applied only to plan administrators), the majority appears to draw a distinction between Kentucky's AWP statute and the AWP statute at issue in *Prudential Ins. Co.*, on the grounds that Kentucky's statute does not specifically state that it applies to "plan administrators." However, §§ 304.17A-110(3) and 304.17A-171(2) apply to "Health Benefit Plans," defined to include HMO and HSC contracts. Similarly, § 304.17A-270 applies to "Health Insurers," defined to include all Insurance Companies, HMOs and HSCs. These definitions in no way limit the applicability of Kentucky's AWP provisions to entities underwriting risk. Consequently, if a self-insurer entered into a contract with an HMO, HSC, or Insurance Company solely for the provision of plan administration, there is no reason that the AWP laws would not apply. A plain reading of the AWP provision compels this conclusion regardless of the law's applicability to the self-insured entity the HMO or HSC contracted with. Consequently, one can only conclude that the AWP provisions are preempted, as by their terms they apply directly to HMO's and HSC's that have merely agreed to operate as administrators of self-insured employee benefit plans.

ited to entities within the insurance industry." *Ward*, 119 S.Ct. at 1386 (internal citations and quotations omitted). The McCarran-Ferguson factors only serve to reinforce my conclusion that Kentucky's AWP laws are not saved from preemption by ERISA § 514(b). While none of the McCarran-Ferguson factors should be seen as dispositive, they provide helpful guideposts for savings clause analysis, lending depth and guidance to the common sense test, particularly in difficult cases such as the one we are presented with. *See Ward* 119 S. Ct. at 1389. With this understanding I begin by considering whether Kentucky's AWP laws have the effect of transferring or spreading policyholder risk.

Appellees argue, and the majority agrees, that the district court was correct in finding that Kentucky's AWP laws spread policyholder risk. The district court reached this conclusion because it believed the laws were similar to the mandated benefit laws that the Supreme Court found to spread risk in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). According to the district court, risk was spread because Kentucky's AWP laws made it more likely that an insurer would cover a visit to a provider that the policyholder may have paid to visit on his or her own, due to the policyholder's preference for that particular provider.

I disagree with the district court's attenuated risk spreading analysis and find its analogy to *Metropolitan Life* to be misplaced. *Metropolitan Life* involved a Massachusetts law which required insurers to provide certain minimum mental health benefits to Massachusetts residents. *Id.* at 724, 105 S. Ct. 2380. While applying the McCarran-Ferguson factors to the Massachusetts law, the Supreme Court concluded that risk was being spread because the statute was intended "to effectuate the legislative judgment that the risk of mental-health care should be shared." *Id.* at 743, 105 S. Ct. 2391.

Mandated benefit laws like the one at issue in *Metropolitan Life* require an insurer to treat individuals with health

care conditions that may not have been covered before the law. The effect of such laws is to shift a significant degree of risk from individuals who originally had no such coverage under the insurance policy, to the insurer. Although a closer question, the same can likely be said for mandated provider laws. Under such laws, an insurance company must provide coverage for treatment from any category of provider,[8] which typically broadens insurance coverage to include forms of alternative medicine (e.g., chiropractic, massage therapy, acupuncture) not previously covered under the policy. The Ninth Circuit confronted such a law in *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (1998). In analyzing whether the law fell under the savings clause as a law regulating insurance, the court began by recognizing that:

> Because insurance is the business of spreading risk, Royal Drug, 440 U.S. at 205, 99 S. Ct. 1067, a state law that regulates the relationship between a carrier and a provider without affecting the risk borne by the insured is outside the definition of insurance regulation. Id. at 213-214, 99 S. Ct. 1067; Hahn v. Oregon Physicians Serv., 689 F.2d 840, 843-844 (9th Cir. 1982).

Id. at 1045. The court concluded, however, that by expanding the kinds of treatment that an insurer must cover to include various types of alternative medicine, the risk that the insured might need alternative medical treatment was shifted to the insurance company. *See Gregoire*, 147 F.3d at 1046. In reaching this conclusion, the court distinguished Washington's mandatory provider law from AWP laws, noting that the mandatory provider statute did not require any carrier to contract or deal with any particular provider; instead it merely forbade a carrier from excluding a particular

[8] The insurance company's ability to use limited provided networks remains unaffected by such a law.

class of provider. *See Gregoire* 147 F.3d at 1046.[9]

AWP statutes such as Kentucky's are different in purpose and effect than either the mandatory benefit or mandatory provider statutes respectively at issue in *Metropolitan Life* and *Gregoire*. Rather than shifting risk from policyholders to insurers, Kentucky's AWP statutes merely prohibit benefit plans from excluding qualified providers who want to join the plan's provider network and are able to meet the plan's requirements. The risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered. The statute's passage in no way alters the terms of the policyholder's policies.[10] The only contracts affected are those between the benefit plan and the providers already in the plan network. Kentucky's AWP laws do not *require* that a single doctor be added to any benefit plan network; benefit plans may still maintain provider networks which require doctors to meet certain terms before joining and the plans may still require that policyholders see plan doctors for their medical costs to be covered. *See* Gary A. Francesconi, Erisa *Preemption of "Any Willing Provider" Laws-An Essential Step Toward National Health Care Reform*, 73 Wash. U. L.Q. 227, 248-49 (1995) (observing that with or without the any willing provider law, the insured's access to certain providers is limited by the policy).

[9] As to the issue of whether AWP laws spread risk, the *Gregoire* court stated that it expressed no opinion. *Gregoire*, 147 F.3d at 1047.

[10] The majority mysteriously concludes that the provision changes the policy between the insured and insurer, "not in terms of covered medical conditions, but in terms of covered treatment by health care providers." However, both the medical risks and corresponding treatment covered by the insurer remain unaltered by Kentucky's AWP law. Consequently, I assume that by this statement the majority really means that by *potentially* expanding the number of plan doctors that one could go to receive treatment for a covered condition, the AWP law somehow changes the contract between the insurer and insured.

While doctors who meet the plans qualifications may independently decide to join the plan and the plan must accept them, many doctors may not meet the plan's qualifications or may have no desire to join that particular plan. For example, in an area with multiple benefit plans, a relatively small percentage of additional qualified doctors may decide to join any particular plan network. In such a scenario, many doctors may already be members of several plan networks and may have no desire to enroll in additional networks. Even those qualified doctors who were previously excluded from all the plans in such an area would be unlikely to join every plan after the AWP law. The result is that although Kentucky's AWP laws make it marginally more likely that a policyholder's benefit plan network will contain their preferred doctor,[11] they will still be restricted to the doctors in their benefit plan network regardless of the membership or non-membership of their preferred doctor.

The Supreme Court discussed the transfer of policyholder risk in detail in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979). The Court was considering whether agreements between Blue Shield and participating pharmacies concerning the price that policyholders would pay for prescriptions, constituted the business of insurance. Under the agreements, the participating pharmacies would fill any Blue Shield policyholder's prescription for a two-dollar charge. *See id.* at 209, 99 S. Ct. at 1072. The pharmacy was then entitled to reimbursement from Blue Shield for the cost of acquiring the drugs prescribed. *See id.* The Court found that, under the antitrust exemption provision of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), the arrangement did not constitute the "business of insurance" because Blue Shield's agreement with the pharmacies merely limited the *amount* that it would

[11] If their doctor met the plans qualifications, had wanted to join the plan, but was denied membership, that doctor could no longer be kept out of the network if he or she still wished to join.

have to pay to cover its policyholder risks. *See id.* at 214-15, 99 S. Ct. at 1075. While realizing that the policyholders might ultimately benefit in the form of lower rates charged by Blue Shield, the Court concluded that no additional policyholder risks were being underwritten. Instead, the Court saw the agreements as merely arrangements for the purchase of goods and services by Blue Shield and thus not the "business of insurance." *See id.* at 214, 99 S. Ct. at 1075.

The majority attempts to distinguish *Royal Drug* on the grounds that "[u]nlike the health plans that are the subject of the Kentucky statute, the insurer in *Royal Drug* did not restrict the number of providers in question." However, the insurer in *Royal Drug* merely *offered* to enter into agreements with each licensed pharmacy in Texas. This is significantly different from actually entering into such agreements, because, as the Supreme Court observed, "only pharmacies that can afford to distribute prescription drugs for less than this $2 markup can profitably participate in the plan." *Id.* at 209, 99 S. Ct. at 1072. As a result, the insurer's promise to enter into agreements with all pharmacies was essentially an empty one, as only larger, high volume pharmacies could afford to enter into such an agreement. Such a hollow offer provides no real basis to distinguish the case from the limited provider networks at issue in the case at bar.

Similarly, Kentucky's AWP laws have almost no effect on the policyholder risk that insurers must underwrite. Like Blue Shield's unchanged obligation to cover a policyholder's prescriptions after entering into the pharmacy agreements, Kentucky insurers must cover the same medical procedures after the AWP law as they would have to if the AWP provision had not been enacted. It is true that the AWP laws would likely force insurers to pay higher rates, however, as in *Royal Drug*, this would only affect the price that insurers must pay for procedures covered in the policies they have issued, not the type of policyholder risks that they con-

tractually must cover.[12] *Accord*, *Prudential Ins. Co.*, 154 F.3d at 828 (finding that the Arkansas AWP statute plainly did not spread risk, and noting that appellants did not even attempt to argue to the contrary).

In discussing the nature of insurance, the *Royal Drug* Court referred to *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959), quoting it for the proposition that "the concept of insurance involves some investment risk-taking on the part of the company." The Court noted that while petitioners didn't dispute this fact, they maintained that the pharmacy agreements did involve the underwriting of risk. To this end, they argued that Blue Shield accepted a premium and assumed the risk that policyholders would need prescription drugs by agreeing to enter into contracts with existing pharmacies to provide such drugs for promised reimbursement from Blue Shield. The Court observed that "the fallacy of petitioner's position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that the policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations." The court then noted that the benefit promised to the policyholders, that they would only have a two-dollar co-payment for any prescriptions, remained unchanged by

[12] Under Kentucky's AWP law, benefit plans can no longer guarantee a limited panel of providers to which other doctors will not be added to handle the plan's patients. To the extent that contracts between benefit plans and providers contained such exclusivity provisions, under the majority's holding they will no longer be enforceable. While the likely result is an increase in the price that insurers must pay, this is not because of an increase in risk, but rather it is due to a decrease in the volume discount an insurer can command if policyholders are spread across a potentially larger network of plan doctors. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 213-15, 99 S. Ct. 1067, 1074-76, 59 L. Ed. 2d 261 (1979).

the arrangement.

As a result the court concluded that Blue Shield's arrangements left policyholders basically unconcerned (from a financial perspective) about the arrangements Blue Shield entered into with participating pharmacies. This is not to say that at least some participants would not be disappointed by the fact that their pharmacy of choice might not have been included, if for example it was not large enough to provide prescriptions for only a two-dollar markup. However, the *financial risks* that Blue Shield agreed to cover remained unchanged, leaving the policyholders without concern for Blue Shield's cost savings agreements with the larger pharmacies.

As the majority notes, in the case at bar the policyholders were also unconcerned with the insurer's compensation arrangements. However, the majority concludes that the policyholders *were* concerned with restrictions on their freedom of choice in seeking medical treatment. Ignoring for a moment the fact that Kentucky's AWP laws do not allow policyholders the freedom to choose their own doctor, and thus only addresses this concern in at best a very tangential way, any concerns over freedom of choice are beside the point. The critical issue with respect to the risk spreading prong, as well as whether the law regulates insurance as a matter of common sense, is whether or not the law is related to the risks underwritten by the insurer. As the Court noted in *Royal Drug*, while discussing the meaning of "business of insurance" under the McCarran-Ferguson Act: "It is important, therefore, to observe at the outset that the statutory language in question here does not except the business of insurance companies from the scope of the antitrust laws. The exemption is for the 'business of insurance,' not the 'business of insurers.'" *Id.* at 210-11, 99 S. Ct. at 1073. Because Kentucky's AWP laws seek to merely regulate the "business of insurers" by dictating how they structure their provider networks, irrespective of the risks they underwrite, they should

not qualify for savings clause protection.

The majority points to *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), as support for its contention that Kentucky's AWP laws do transfer risk. *Stuart Circle* involved a Virginia statute which required insurers to accept any willing provider if they established preferred provider networks. The court concluded that while the statute "related to" ERISA plans, it was not preempted, because it fell within ERISA's savings clause as a law regulating insurance. *Id.* at 504. After finding the common sense test satisfied, in part because the law was located within Virginia's insurance code,[13] the court moved on to the McCarran-Ferguson factors. Discussing whether the law transferred or spread policyholder risk, the court concluded that the Virginia statute "affects the type and cost of treatment available to an insured." *Id.* The court reached this conclusion because it believed that without the AWP law, policyholders might on occasion attend a doctor outside of their plan network, due to a personal preference for that doctor, and in doing so, would be forced to shoulder all or part of the cost. *See id.*

I am underpersuaded by the majority's argument that *Stuart Circle's* attenuated risk spreading rationale should be applied to Kentucky's AWP laws. As I have discussed, Kentucky's AWP laws do not require health benefit plans to in-

[13] As indicated above, this fact should have little to do with determining whether a law is specifically directed at the insurance industry, as any law may be inserted within the insurance provisions of a state code. Further, the Virginia statute at issue, § 38.2-3407, only applied to "insurers," defined within the Chapter to mean "an insurance company" which is itself defined as "any company engaged in the business of making contracts of insurance." Va. Code Ann. § 38.2-100. Thus, Virginia's AWP statute was more narrow in scope than Kentucky's, quite specifically limiting its application to the term "insurance companies," defined by the statute to include only companies actively issuing insurance contracts. Consequently, Virginia's statute would clearly not apply to entities engaged in only administrative functions for an employee benefit plan.

clude a single additional provider unless the qualified provider, not the policyholder, decides to join the plan. Policyholders are not necessarily any better off than they were before the law was passed, only benefiting from the law if their provider is both willing to join their particular provider network and able to meet its requirements. The insurance policy and the contingencies it underwrites, *i.e.*, the risk that insured will need medical treatment for a condition covered under the policy, remain the same, regardless of Kentucky's AWP law.[14] There is no shifting of the risk between the policyholder and insurer that a specific medical contingency will occur.

The majority attempts to escape from *Royal Drug's* teaching by relying on dicta from *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), in which the court questioned "whether the holding of *Royal Drug* may be translated into the ERISA preemption context at all." *Id.* at 72. The *American Drug*

[14] The conclusion that Kentucky's AWP laws are not the business of insurance is supported by the following rhetorical question which the Supreme Court posed in *Royal Drug*. The court addressed a scenario which essentially involved limited provider networks, stating:

> Suppose, for example, that an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain. The justification for such an agreement would be administrative and bulk-purchase savings resulting from obtaining all of the company's drug needs form a single dealer. Even though these cost savings might ultimately be reflected in lower premiums to policyholders, would such a contract be the "business of insurance?" Or suppose that the insurance company should decide to acquire the chain of drug stores in order to lower still further its costs of meeting its obligations to its policyholders. Such an acquisition would surely not be the "business of insurance."

440 U.S. at 215, 99 S. Ct. at 1075. If such agreements are not the "business of insurance," then it follows that a state's attempts to regulate these agreements would not qualify as such either.

Store court was referring to the fact that *Royal Drug* interpreted the scope of the antitrust exemption under § 2*(b)* of the McCarran-Ferguson Act, but did not address §§ 1 and 2(a) of the act, which preserved a State's ability to regulate the "business of insurance" from Commerce Clause attack. *See Royal Drug*, 440 U.S. at 219 n.18, 99 S. Ct. at 1077.[15] However, the Supreme Court has not indicated that it is troubled by this distinction. As recently as last term, the Court employed the McCarran-Ferguson factors it created in *Royal Drug* and imported into ERISA preemption analysis in *Metropolitan Life*, without any indication that its past precedent interpreting whether a law "regulates insurance" under ERISA's savings clause was called into doubt. *See Ward*, 119 S.Ct. 1380, 1388 (1999).[16] Until the Court indicates that its *Royal Drug* business of insurance test is no longer appropriate in the ERISA savings clause context, something that it has yet to do, I believe we must continue to apply the test as dictated by the Court's precedent.

Moving to the second McCarran-Ferguson factor, I consider whether Kentucky's AWP laws affect an integral part of the policy relationship between the insurer and insured. The majority asserts that the district court was correct in

[15] The majority appears to be persuaded by this reasoning. I do not draw the same conclusion. However, even if the meaning of "business of insurance" was broadened beyond the contractual relationship between the policyholder and insurer, I do not believe that Kentucky's AWP law would qualify. As I have explained elsewhere, Kentucky's AWP laws have at most a speculative and tangential effect on this relationship.

[16] The district court in *Community Health Partners v. Commonwealth of Kentucky*, 14 F.Supp.2d 991 (W.D. Ky. 1998) observed that *United States v. Fabe*, *508* U.S. 491, 113 S. Ct. 2202, 124 L. Ed.2d 449 (1993) might be argued to change and broaden savings clause analysis in the ERISA context. However, other federal courts have not reached this conclusion and the Supreme Courts most recent opinion in *Ward* gives no indication that the Court's savings clause analysis has changed. *See also, Prudential Ins. Co.*, 154 F.3d at 827-828 (concluding that *Fabe* had no effect on savings clause analysis).

finding that Kentucky's AWP laws dictate a substantive term of the contract between the insurer and insured and are thus an integral part of this relationship. As support for this proposition, the majority again cites *Stuart Circle*, which concluded that because Virginia's AWP law affected treatment and cost (through the same attenuated manner in which the court concluded risk was spread) it was integral to the insurer-insured relationship. 995 F.2d 500 at 503.

Again I find *Stuart Circle* unconvincing. The effect of Kentucky's AWP laws center on the insurer-provider relationship. The terms of the insurer-insured relationship are only affected in a very indirect manner, making it difficult to see the AWP laws as integral to that relationship. *See Prudential Ins. Co.*, 154 F.3d at 830 (finding the Arkansas AWP law not to be integral to the insurer-insured relationship, as it defined only the terms between the insurer and providers, and distinguishing *Gregoire* because Washington's any category of provider law *did* affect the insurer-insured relationship by expanding the kinds of treatment the policy must cover). *Cf.*, *Pilot Life Co. v. Dedeaux*, 481 U.S. 41, 50-51, 107 S. Ct. 1549, 1554-55 (1987) (noting that Mississippi's law of bad faith, in contrast to the mandated benefits law in Metropolitan Life, did not define the terms between the insurer and insured, and thus only affected the insurer-insured relationship in an attenuated way). The Court's discussion of California's notice-prejudice rule in *Unum Life Ins. Co. of America v. Ward*, 119 S. Ct. at 1389-90 (1999), provides an illuminating example of what qualifies as an integral policy relationship under the McCarran-Ferguson factors. The Supreme Court observed that:

> [California's notice-prejudice rule] serves as an integral part of the policy relationship between the insurer and insured. *Metropolitan Life*, 471 U.S. at 743, 105 S. Ct. 2380. California's rule changes the bargain between insurer and insured; it effectively creates a

> mandatory contract term that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision.

Id. In sharp contrast, Kentucky's AWP provisions leave the contract terms between the insurer and insured, unaltered. The relationships directly affected by the law are those existing between insurers and third. parties *(i.e.*, medical providers). As discussed above, the medical risks covered by the policy remain the same. Thus, even if an insured's preferred provider decides to join the insured's network, and complies with its terms in doing so, the medical coverage that the insurer has contracted to underwrite remains unchanged. Unlike the mandated benefit laws at issue in *Metropolitan Life*, the mandated provider law in *Gregoire*, or the mandatory notice-prejudice rule in *Ward*, Kentucky's AWP laws do not force the insurer to offer a benefit to insureds tha. was not available before the law. Rather, Kentucky's AWP laws merely force insurers to potentially make additional contractual arrangements with providers they might otherwise exclude. The medical conditions covered remain unaffected and the insureds are still limited to the plan's network of providers. Therefore, I must conclude that Kentucky's AWP law is not integral to the insured-insurer relationship.

Finally, I consider whether the Kentucky AWP laws are limited to entities within the insurance industry. As discussed under the common sense test, I do not believe this to be the case. The law not only regulates entities that fall outside the traditional definition of insurer, it also extends to include entities in no way involved in underwriting risks. In fact, a review of the statute shows that while it may affect the way that some insurance companies run their business, it has nothing to do with the underwriting of risk, the traditional earmark of insurance. *See Royal Drug*, 440 U.S. at 211-12, 99 S. Ct. at 1073-74. Accordingly, I believe that Kentucky's AWP laws fail the third prong of the McCarran-Ferguson

test as well.

In sum, I am forced to conclude that §§ 304.17A-110(3) and 304.17A-171(2), Kentucky's AWP laws, are not saved from preemption as laws that regulate the business of insurance, because under ERISA § 514(b), they fail to meet not only the common sense test, but also all of the McCarran-Ferguson factors.[17] While federalism concerns prohibit federal courts from lightly preempting acts of a state legislature, I agree with the Eighth Circuit's observation in *Prudential Ins. Co.* that, "it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care." *Prudential Ins. Co.*, 154 F.3d at 829-30.

II. Severability

Because I believe that Kentucky's AWP provisions, Ky. Rev. Stat. Ann. § 304.17A-110(3) and 304.17A-171 (2) (Banks-Baldwin 1995), are preempted by 29 U.S.C. § 1144(a) and not saved by the savings clause of 29 U.S.C. § 1144(b)(2)(A), I write separately to address whether the laws should be invalidated in their entirety, or whether the offending provisions of the statutes may be severed in whole or part. While never explicitly stating so, as discussed above, the majority appears to agree that Kentucky's AWP laws are preempted at least in their application to HMOs and HSCs who are performing administrative or related duties for self-insured employee benefit plans. However, despite implicitly drawing this conclusion, the majority still concludes that the AWP law is saved by the insurance savings clause. In doing so, the majority fails to mention, let alone discuss, how it severs Kentucky's AWP provision in such a manner that it no longer applies to third party plan administrators performing administrative functions for self-insured plans, thereby

[17] As we indicated above, the parties have agreed that our holding with regard to § 304.17A-110(3) will serve to determine whether § 304.17A-270 is preempted as well.

allowing it to conclude that the provision is saved in all other applications.

The Supreme Court has often stated that the inquiry into whether a statute is severable is essentially an inquiry into legislative intent. *See, e.g., Minnesota v. Mille Lacs Band of Chippewa Indians,* 119 S. Ct. 1187, 143 L. Ed. 2d 270 (1999); *Zobel v. Williams,* 457 U.S. 55, 64, 102 S. Ct. 2309, 2315, 72 L. Ed. 2d 672 (1982); *Regan v. Time, Inc.,* 468 U.S. 641, 653, 104 S. Ct. 3262, 3269, 82 L. Ed. 2d 487 (1984) (plurality opinion). In discerning the legislature's intent, the Court has directed that:

> Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law. *Champlin Refining Co. v. Corporation Comm'n of Okla.,* 286 U.S. 210, 234, 52 S. Ct. 559, 76 L. Ed. 1062 (1932). See also *Alaska Airlines, Inc. v. Brock,* 480 U.S. 678, 684, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987); *Regan v. Time, Inc.,* supra, at 653, 104 S. Ct. 3262.

Mille Lacs Band of Chippewa Indians, 119 S. Ct. at 1198. Therefore, as evidence of the legislature's intent I look to Kentucky's severability statute, which states:

> It shall be considered that it is the intent of the general assembly in enacting any statute, that if any part of the statute be held unconstitutional the remaining parts shall remain in force, unless the statute provides otherwise, or unless the remaining parts are so essentially and inseparably connected with and dependent upon the unconstitutional part that it is apparent that the general assembly would not have enacted the remaining parts without the unconstitutional part, or unless the remaining parts, standing alone, are incomplete and incapable of being executed in accordance with

the intent of the general assembly.

Ky. Rev. Stat. Ann. § 446.090. The statute indicates that if any part of a Kentucky statute is found unconstitutional, it is the legislature's intent that the remaining provisions be saved. However, in drafting the statute the legislature also recognized that situations will exist where severing the offending parts cannot be considered as it would make it impossible to carry out the original legislative intent.

I begin my severability inquiry by addressing whether portions of Ky. Rev. Stat. Ann. §§ 304.17A-110(3) and 304.17A-171(2) may be severed in such a way that the provisions would not be preempted in their entirety. Because I believe that §§ 304.17A-110(3) and 304.17A-171(2) contain an impermissible connection with ERISA covered plans, there is no way to save the provisions themselves from preemption by severing particular parts while leaving the rest intact. Even if it were possible to do so, merely removing any prohibited "references to" ERISA plans would not suffice. The Kentucky provisions impermissible "connection with" ERISA plans would continue, as ERISA plans would still be effectively prohibited from offering limited provider panels, as none would be available to them. The only way that §§ 304.17A-110(3) and 304.17A-171(2) could be saved, would be to add language effectively allowing health care entities to offer limited provider networks to ERISA covered plans. Because both Kentucky and federal case law prohibit us from adding language to a state statute to remove its conflict with federal law, see, e.g., *Musselman v. Commonwealth*, 705 S.W.2d 476, 477 (Ky. 1986), *Eubanks v. Wilkinson*, 937 F.2d 118, 120 (6th Cir. 1991), I conclude that §§ 304.17A-110(3) and 304.17A-171(2) are preempted in their entirety. *See Prudential Ins. Co.*, 154 F.3d at 832 (concluding that the AWP statute at issue was preempted in its entirety); *Texas Pharmacy Ass'n*, 105 F.3d at 1039 (drawing the same conclusion).

Finally, I address whether the preempted provisions, provision (3) of § 304.17A-110 and provision (2) of § 304.17A-171, may be severed from their respective statutory sections or whether the sections must also be preempted. Kentucky's severability statute indicates that unconstitutional provisions may presumptively be severed, unless severing the offending provisions makes it impossible to execute the remaining provisions of a statute in the manner the legislature intended. It is clear that §§ 304.17A-110 and 304.17A-171 can be executed in accordance with the legislature's original intention without provision (3) and (2) respectively. Accordingly, while I conclude that §§ 304.17A-110(3) and 304.17A-171(2) should be preempted in their entirety, the statutory sections they reside in should remain unaffected.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
FRANKFORT

CIVIL ACTION NO. 97-24

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC., et al., Plaintiffs,

v.

GEORGE NICHOLS, III, in his Official Capacity as Commissioner of the Kentucky Department of Insurance, Defendant.

MEMORANDUM OPINION AND ORDER

This matter is before the Court on the parties' cross-motion for partial summary judgment. The plaintiffs, Health Maintenance Organization of Kentucky, Inc., Advantage Care, Inc., Aetna Health Plans of Ohio, Inc., ChoiceCare Health Plans, Inc., FHP of Ohio, Inc., HMPK, Inc., and Humana Health Plan, Inc., submit that partial summary judgment for the plaintiffs is appropriate in this matter as the statutes at hand are preempted by ERISA. The defendant, George Nichols, III, in his official capacity as Commissioner of the Kentucky Department of Insurance ("Commissioner Nichols"), argues, however, that summary judgment is appropriate for him as the statutes at hand only indirectly affect ERISA benefit plans, and thus are not preempted.

Being fully briefed, this matter is ripe for decision. Having considered the parties' arguments, the Court finds that summary judgment is warranted for Commissioner Nichols. Having so determined, the Court makes the following findings of facts consistent with such a determination.

FINDINGS OF FACT

The plaintiffs are licensed health maintenance organizations ("HMOs"), which provide health care services to voluntarily enrolled persons. In order to provide these services within a reasonable cost, the plaintiffs have developed "managed care" programs. Many Kentucky employers have utilized this "managed care" system when offering health care to their employees. Such employer-sponsored health care plans are considered "employee benefit plans" under ERISA.

The plaintiffs have filed this declaratory judgment action, arguing that certain provisions within the Kentucky Health Care Reform Act should be enjoined form enforcement as the provisions either violate the United States Constitution or are preempted by federal law. These provisions are known as Kentucky's "Any Willing Provider" ("AWP") statute and Kentucky's Chiropractic statute, KRS 304.17A-110(3) and KRS 304.17A-171, respectively. Specifically, the plaintiffs contend that these statutes (1) violate the plaintiffs' rights to due process and equal protection and (2) are preempted by ERISA, 29 U.S.C. § 1001, et seq., by the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e, et seq., and by the Federal Health Benefit Improvement Act, 5 U.S.C. § 8901, et seq.

Pursuant to an agreement by the parties, only Count I of the complaint, alleging that the statutes are preempted by ERISA, is presently before the Court. In their joint status report, the parties agreed that discovery would be had and dispositive motions would be filed only as to Count I. When Count I is resolved, the case will then proceed forward on the other five counts, Counts II-VI. Accordingly, the parties have both filed motions for partial summary judgment as to Count I.

The plaintiffs move the Count for a partial summary judgment, arguing that the AWP and Chiropractic statutes

(hereinafter referred to collectively as the "AWP Statutes)[1] are preempted by ERISA. The plaintiffs subnit that the AWP statutes are preempted by ERISA because the statutes "relate to" employee benefit plans. The plaintiffs submit that the AWP statutes refer to employee benefit plans prohibiting such plans form creating limited provider networks. The plaintiffs maintain, inter alia, that the AWP statues (1) interfere with a plans' ability to negotiate with provicers, (2) impose additional administrative costs on the plan, 3) interfere with a plan's discretion as to how health benefits should be delivered and (4) eliminate a method of structurng benefits that is permissible under ERISA. Accordingly, tle plaintiffs contend that the AWP statutes unconstitutionally intrude upon an area preempted by ERISA, and therefore these statutes must be held invalid and unenforceable under the Supremacy Clause of the United States Constitution.

Commissioner Nichols counters that the AVP statutes are not preempted. He argues that the AWP statutes do not "relate to" employee benefit plans, but instead, such statutes merely have an indirect, economic influence which is too tenuous to require preemption. He states, however, that even if the statutes were to be preempted as "relating to" an employee benefit plan, such statues would be "saved' from preemption because these statutes "regulate" the insurance industry, which is an area exempted from ERISA preemption. However, Commissioner Nichols argues that the Court should not even entertain such preemption argument since the plaintiffs do not have "standing" to bring this suit.

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[1] Although the Chiropractic statute imposes additional requirement s on health benefit plans than does the AWP statute, both statues similarly define "health benefit plan," and thus, the Court will refer to these statutes collectively when determining if they are preempted under ERISA.

[2] The plaintiff also argue that the statutes must be stricken in their entirety and cannot be limited to non-ERISA benefit plans. The Court, however, does not address this issue since the Court has ultimately found that the statute need not be stricken as it is "saved" from preemption.

CONCLUSIONS OF LAW

I. The Plaintiffs Have Standing To Bring This Action

As noted above, Commissioner Nichols argues that the plaintiffs do not have standing to bring this action.[3] The Court does not agree.

The plaintiffs bring this action seeking a declaration that the AWP statute is unconstitutional because it is preempted by ERISA. The plaintiffs have standing to bring such action as they are affected by the terms of the statute in their role as administrators of health benefit plans. It is clear that if the statute is enforced the plaintiffs will suffer economic injury and if the Court grants the HMO plaintiffs the remedy they seek, i.e. preemption, their economic injury would be redressed. See CIGNA Healthplan v. Louisiana, 883 F. Supp. 94, 101 (M.D. La. 1995), aff'd, 82 F. 3d 642 (5th Cir.), cert. denied, 117 S. Ct. 387 (1996). Accordingly, the Court finds the standing argument merit less, and will proceed forward on the issue of whether the AWP statutes are preempted by ERISA.

II. ERISA Preemption

Whether ERISA preempts mandated-benefit or man-

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[3] Commissioner Nichols also argues that the plaintiffs have failed to show that they are in fact administrators of ERISA plans. By the affidavits put forth by the plaintiffs, the Court finds that the plaintiffs have sufficiently shown that they are administrators of employee benefit plans. AS the Sixth Circuit noted, "Employers may establish ERISA plans very easily. As defined under ERISA, employee welfare benefit plans may be created through the mere purchase of a group health insurance policy when the owner does not retain control, administrative power, or responsibility for benefits." Libbey-Owens-Ford v. Blue Cross & Blue Shield Mut., 982 F.2d 1031 (6th Cir.) (internal citations omitted), cert. denied, 510 U.S. 819 (1993; see also Fugarino v. Hartford Life & Accident Ins. Co., 969 F.2d 17, 183 (6th Cir. 1992) ("[I]t is a common practice for employers to provide health care benefits to their employees through the purchase of a group health insurance policy from a commercial insurance company."), cert. denied, 507 U.S. 966 (1993).

dated-provider laws is a subject of great contention. Many courts have addressed this issue, but little agreement has arisen from such decisions.

Some courts have found that the laws doe not even relate to ERISA, and therefore such laws are not preempted. See Washington Physicians Serv. Ass'n v. Gregoire, ___ F.3d ___, 1998 WL 318759 (9th Cir. 1998), rev'g, 967 F. Supp. 424 (W.D. Wash. 1997)); American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60, 69 (D. Mass. 1997); Foster v. Blue Cross Blue Shield, 969 F. Supp. 1020, 1027 (E.D. Mich. 1997). Other courts, including the Federal District Court for the Western District of Kentucky, have determined that the laws do relate to ERISA, but nevertheless are "saved" from preemption because they regulate the business of insurance. See Stuart Circle Hosp. Corp. v. Aetna Health Management, 995 F.2d 500, 501 (4th Cir.), cert. denied, 510 U.S. 1003 (1993); Blue Cross & Blue Shield v. Bell, 798 F.2d 1331, 1336 (10th Cir. 1986); Community Health Partners, Inc. v. Kentucky, ___ F. Supp. 2d ___, 1998 WL 325259 (W.D. Ky. 1998); , ___ F. Supp. 2d ___, 1998 WL 325259 (W.D. Ky. 1998); Texas Pharmacy Ass'n v. Prudential Ins. Co., 907 F. Supp. 1019, 1025-26 (W.D. Tex. 1995), aff'd as modified, 105 F.3d 1035, 1042 (5th Cir.), cert. denied, 118 S. Ct. 75 (1997. Lastly, a few courts have determined that the laws relate to ERISA and are not "saved," since they do not meet the Supreme Court's two-part test for regulating the business of insurance. See Prudential Ins. Co. v. National Park Med. Ctr., Inc., 964 F. Supp. 1285, 1296-99 (E.D. Ark. 1997); CIGNA Healthplan, 883 F. Supp. at 102-104, aff'd, 82 F.3d 642 (5th Cir. 1996); HCA Health Servs. v. Aetna Life Ins. Co., 803 F. Supp. 1132 (E.D. Va. 1992).

Having reviewed the many decisions on this subject, the Court finds that Kentucky's AWP statutes do relate to ERISA plans and are saved from preemption because they regulate the business of insurance.

A. ERISA's Preemptive Structure

ERISA clearly preempts state law which deals with employee benefit plans. 29 U.S.C. 1144(a) (emphasis added) states,

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

Subsection (b), however, goes on to state that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b) (2) (A) (emphasis added). Subsection (b) thus "saves" State law from preemption if the law regulates in three areas set forth.[4]

Yet, within subsection (b), another exception is carved out; this exception is known as the "deemer clause." The "deemer clause" provides that an employee benefit plan

> shall [not] be deemed to be an insurance company or other insurer, bank trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b) (2) (B) (emphasis added). Thus, the "deemer clause" does not allow a state statute to be "saved" when regulating a "self-funded employee benefit plan" under ERISA. See Electro-Mechanical Corp. v. Ogan, 9 F.3d 445,

[4] Thus this subsection is known as the "saving clause."

450-51 (6th Cir. 1993).[5]

In analyzing, then, a State statute such as the one at hand, the first question is whether the state statute "relates to" an employee benefit plan, and therefore is preempted. Looking at the AWP statutes the Court finds the answer to that question to be "yes." The AWP statutes do "relate to" employee benefit plans.

B. AWP Statutes Relate to Employee Benefit Plans Within The Meaning of ERISA

The AWP statutes provide,

> Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.

KRS 304.17A-110(3); see also KRS 304.17A-171 (stating that a health benefit plan must permit any licensed chiropractor, who is willing to meet the plan's standards, to serve as a provider). Health benefit plan is defined as follows:

> [A]ny hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health

[5] The savings clause limits preemption of state insurance laws to the extent it could be read to "exempt or relieve any person from [state insurance law]." 29 U.S.C. § 1144 (b) (2) (A) (emphasis added). The deemer clause, in turn, qualifies the savings clause and insures that state will not treat ERISA plans as "persons" subject to state laws enumerated in the savings clause. Finally, the MEWA clause is a limited exception to the deemer clause, and allows states to regulate MEWA-sponsored plans as if they were engaged in the business of insurance.

> In this fashion, Congress satisfied its goal of reserving to the states regulation of the business of insurance and protecting ERISA plans themselves from being subjected to state and local regulation.

Fuller v. Norton, 86 F.3d 1016, 1024 (10th Cir. 1996).

> service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated health delivery network; a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160.

KRS 304.17A-100(4) (a) (emphasis added); see also KRS 304.17A-170(1)(a). Thus, looking at the above provisions it is clear that the AWP statutes "refer to" employee benefit plans. See Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 108 S. Ct. 2182, 2186 & n.4 (1988) (statute expressly referred to an employee benefit plan when it singled it out for different treatment); see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 117 S. Ct. 1747, 1752 & n.15 (1997) (acknowledging that ERISA supersedes laws which contain provisions that expressly refer to ERISA or ERISA plans). But see California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 117 S. Ct. 832, 838 (1998) (noting that "[w]here a State's law acts immediately and exclusively upon ERISA plans" or "where the existence of ERISA plans is essential to the law's operation" the law "refers to" an ERISA plan and is therefore preempted); Community Health Partners, Inc., 1998 WL 325259 at *3 - *4.[6]

[6] The Western District of Kentucky in Community Health Partners, Inc. v. Kentucky, ___ F. Supp. ___, 1998 WL 325259 (W.D. Ky. 1998), determined that Kentucky's AWP statute does not "refer to" an ERISA plan (1) because the law does not act "'immediately and exclusively upon ERISA plans", id. at *3 (quoting Dillingham Constr., N.A., Inc., 117 S. Ct. at 838), and (2) because "the existence of ERISA plans is [not] essential to the law's operation.'" Id. at *4 (quoting Dillingham Constr., N.A., Inc., 117 S. Ct. at 834). The Court, however, does not agree.

Even if the Court were to find that the AWP statutes do not "refer to" ERISA plans, the Court still finds that the AWP statutes are preempted because the statutes have a "connection with" employee benefit plans. The statutes affect how the plans may be administered by requiring such plans to not discriminate as to health care providers, and thus require the plans to contract with "any willing provider." See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995) (looking to prior Supreme Court cases, the Court noted that in those cases "ERISA preempted state laws that mandated employee benefit structures or their administration.")

While such requirements do have an economic impact on the plans, the requirements do more than that; the requirement to contract with "any willing provider" directs the administrator of the plan as to how the plan must be administered, and thus, how the benefit package for the employee must be set up.

Hence, when analyzing the Supreme Court cases dealing with preemption, this case is more closely aligned with Shaw v. Delta Air Lines, Inc. 463 U.S. 85 (1983), than with Dillingham Construction, N.A., Inc., 117 S. Ct. 832 (1997). In Shaw the Court found that New York's Human Rights Law and Disability Benefits Law had a "connection with" employee benefit plans because such laws imposed certain restrictions on the set up of employee benefit plans. The Court

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Both Dillingham Constr., N.A., Inc., 117 S. Ct. at 838, and De Buono, 117 S. Ct. at 1752, cite Mackey for a situation where a statute refers to ERISA or an ERISA plan. Mackey makes it clear that when a statue "singles out ERISA employee welfare benefits plans for different treatment" the statute's "express reference to ERISA plans suffices to bring it within the federal law's pre-emptive reach." Mackey, 108 S. Ct. at 2186. Thus, even though a mere reference to ERISA "alone" may not be sufficient, in this case the AWP statute does not single out and treat ERISA employee welfare benefit plans differently, and thus does "refer to" an ERISA plan so that the statute is preempted.

found,

> We have no difficulty in concluding that the Human Rights Law and Disability Benefits Law "relate to" employee benefit plans. The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. Employing this definition, the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly "relate to" benefit plans.

Shaw, 463 U.S. at 96-97 (internal footnotes omitted) (emphasis added).

In Dillingham Construction, N.A., Inc., the Supreme Court, however, determined that California's prevailing wage law did not have a "connection with" employee benefit plans because, unlike the statutes in Shaw, the wage law did not mandate any particular structure for benefit plans and only impacted on such plans indirectly. Finding that California's wage law was closely aligned with the law discussed in its most recent decision, Travelers Ins. Co., 115 S. Ct. 1671 (1995), the Court held,

> Like New York's surcharge requirement, the apprenticeship portion of the prevailing wage statute does not bind ERISA plans to anything. NO apprenticeship program is required by California law to meet California's standards ... The effect of § 1777.5 on ERISA apprenticeship programs, therefore, is merely to provide some measure of economic incentive to comport with the State's requirements ...
>
> The effect of the prevailing wage statute on ER-

> ISA-covered apprenticeship programs in California is substantially similar to the effect of New York law on ERISA plans choosing whether to provide health insurance benefits in New York through the Blues, or through a commercial carrier. The prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans. In this regard, it is "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." We could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing f that sort. We thus conclude that California's prevailing wage laws and apprenticeship standards do not have a "connection with," and therefore do not relate to," ERISA plans.

Dillingham Construction, N.A., Inc., 117 S. Ct. at 841-42 (internal citations and footnotes omitted) (emphasis added).

Reviewing Shaw and Dillingham Construction, N.A., Inc., then, it is clear that the AWP statutes do more than indirectly affect the costs of ERISA plans; the AWP statutes mandate benefit structures.[7] Thus, the AWP statutes have a "connection with" ERISA plans and are therefore preempted because they "relate to" ERISA plans. As the Fifth Circuit eloquently expressed when looking at Louisiana's "any willing provider statute,"

[7] It is sufficient for preemption purposes that the statute eliminates the choice of one method of structuring benefits. The fact that neither CIGNA nor CGLIC is itself an ERISA plan is likewise inconsequential: By denying insurers, employers, and HMOs the right to structure their benefits in a particular manner, the statute is effectively requiring ERISA plans to purchase benefits of a particular structure when they contract with organizations like CIGNA and CGLIC. In that regard, the statute "bears indirectly but substantially on all insured plans," and is accordingly preempted by ERISA. CIGNA Healthplan, 82 F.3d 642, 648 (5th Cir. 1996) (Internal footnotes omitted).

> Unlike the New York statue at issue in Travelers, Louisiana's Any Willing Provider statute specifically mandate s that certain benefits available to ERISA plans must be constructed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure. As such, the statute falls outside the purview of the limited Travelers holding: The Court there repeatedly recognized that ERISA preempts "state laws that madate[e] employee benefit structures." Accordingly, we hold that the Travelers decision leaves undisturbed our conclusion that Louisiana's Any Willing Provider statute is preempted by ERISA.

CIGNA Healthplan, 82 F.3d at 649 (internal footnotes omitted).

Having determined that the AWP statutes are more closely aligned with Shaw, and thus "relate to" to employee benefit plans, the AWP statutes will be preempted unless they can be "saved" by ERISA's savings clause. Thus, the question now becomes, do the AWP statutes "regulate the business of insurance?" The Court finds that they do.

C. The AWP Statutes Regulate The Business of Insurance And Therefore Are Saved From Preemption

Whether the AWP statutes are "saved" from preemption by the savings clause is a difficult question and a close call. In determining whether the "savings clause" of ERISA allows Kentucky to enact and enforce the AWP statutes because they regulate insurance, the Court must determine whether the AWP statutes meet the common sense test and

the three factor test under the McCarran-Ferguson Act.[8] Under the three factor test, in order for the statute to be considered as regulating the business of insurance, the statute must

> (1) ha[ve] the effect of transferring or spreading the policyholders' risk
>
> (2) constitute[] an integral part of the policy relationship between the insurer and the insured; and
>
> (3) [be] limited[ed] to entities within the insurance industry.

International Resources, Inc. v. New York Life Insurance. Co., 950 F.2d 294, 299 (6th Cir. 1991) (citing McMahan v. New England Mut. Life Ins. Co., 888 F.2d 426, 429 (6th Cir. 1989)), cert denied, 504 U.S. 973 (1992).

The plaintiffs in their partial motion for summary judgment have made a good argument that the savings clause does not apply in this situation. Nevertheless, the Court finds that the savings clause does apply and that the AWP statutes are laws which "regulate" insurance.[9]

At first blush, it appears that he AWP statutes do not "regulate" insurance (1) because the statutes are directed at not only insurance entities, but also hospitals, HMOs, etc., and (2) because the statutes do not appear to spread the

[8] Unlike some courts, the Sixth Circuit does not require both tests and all factors to be met. The Sixth Circuit instead has stated that "[t]hese criteria must be considered in combination, and, standing alone, no single one is dispositive." Davies v. Centennial Life Ins. Co., 128 F.3d 934, 940 (6th Cir. 1997). Cf. Texas Pharmacy Ass'n v. Prudential Ins. Co., 105 F.3d 1035, 1038 (5th Cir.) (quoting CIGNA Healthplan v. Louisiana, 82 F.3d 642, 650 (5th Cir. 1996)), cert. Denied, 118 S.Ct. 75 (1997).

[9] Although the Court could make an argument that the statute is not "saved," as many courts have done, the Court finds the Supreme Court case of Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 2390-91 (1985), to be compelling and instrumental in determining that the AWP statute is indeed "saved."

"risk" of insurance since the statutes do not necessarily deal with losses or risk of injury. See Davies v. Centennial Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 2390-91 (1985), the Court cannot help but find that the statute does "regulate" insurance.

In Metropolitan Life Ins. Co., the Supreme court found that a mandated-benefits statute regulated insurance. The Court found that the application of the McCarran-Ferguson Act criteria "suggest[ed] that mandated-benefit laws are state regulation of the 'business of insurance.'" Id. at 2391. In so finding the Court looked at each factor and made the following conclusions:

> Section 47B [mandated-benefit law] obviously regulates the spreading of risk: as we have indicated, it was intended to effectuate the legislative judgment that the risk of mental-health care should be shared. It is also evident that mandated-benefits laws directly regulate an integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder. Finally, the third criterion is present here, for mandated-benefit statutes impose requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder. Section 47B, then, is the very kind of regulation that this Court has identified as a law that relates to the regulation of the business of insurance as defined in the McCarran-Ferguson Act:
>
> > Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the *type of policy which could be issued*, its reliability, it interpretation, and enforcement – these were the core of the 'busi-

> ness of insurance.' **[T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'"** *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed.2d 668 (1969) (emphasis added).

Nor is there any contrary case authority suggesting that laws regulating the terms of insurance contracts should not be understood as laws that regulate insurance. **In short, the plain language of the saving clause its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulation, all lead us to the conclusion that mandated-benefit laws such as § 47B are saved from pre-emption by the operation of the saving clause.**

Id. (emphasis added) (internal footnotes omitted).

Like the mandated-benefits law discussed in Metropolitan Life Ins. Co., the AWP statutes also direct the "type of policy which could be issued," Id. (quoting SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969)), to the employee benefit plans; thus, the statutes regulate an integral part of the relationship between the insurer and policyholder. See Stuart Circle Hosp. Corp., 995 F.2d at 503 (finding that Virginia's "mandated-provider statute is an integral part of the policy relationship because "mandatory-provider regulations are conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance"); Bell, 798 F.2d at 1335 (noting that the "freedom to choose a treating physician is inextricable from the nature of the coverage provided" and thus a mandated-provider law is integral to the relationship between insurer and insured).

Likewise, the AWP statutes are similar to the statute in Metropolitan Life Ins. Co. in that the AWP statutes spread the policyholder's risk. Although some courts have determined that mandated-provider laws do not spread the risk because such laws only regulate the carrier-provider relationship and not the insurer-insured relationship, see Gregoire, 967 F. Supp. at 430 ("While there may be an indirect effect, this is insufficient to satisfy this element - it must be integral, and a contract between a carrier and provider is not integral to carrier/subscriber relationship."), rev'd, 1998 WL 318759 (9th Cir. 1998); Prudential Ins. Co., 964 F. Supp. at 1298 ("These contracts and provider networks are related to the insurance contract between insurers and their insureds but are not an integral part of the policy relationship between the insurer and insured."), the Court finds that the mandated-provider laws do regulate more than just the carrier-provider relationship since the laws "effectively transfer some degree of financial risk from the insured to the insurer." Community Health Partners, Inc., 1998 WL 325259 at *12.

> The Virginia [mandated-providers statute satisfies the first criterion, "transferring or spreading the policyholder's risk." **There are several components to the "policyholder's risk."** They include the types of illness and injury that the insurance contract covers, provision for treatment, and the cost of treatment. **The Virginia statute affects the type and cost of treatment available to an insured**. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. **By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of**

the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

Stuart Circle Hosp Corp., 995 F.2d at 503 (emphasis added); see also Bell, 798 F.2d at 1335 ("The choice of a provider does not add to the insured's coverage but is of the essence of that coverage bargained for as the transferred risk.").

Lastly, the AWP statutes are "limited to entities 'within the insurance industry, since all carriers are in the business of accepting the risk of providing health care coverage for a fee. The Supreme Court has recognized that a statute which 'impose [s] requirements only on insurers, with the intent of affecting the relationship between the insurer and the Policyholder' satisfies this third prong." American Drug Stores, 973 F. Supp. At 71 (quoting Metropolitan Life Ins. Co., 105 S.Ct. at 2391).

Although the AWP statutes do address entities not deemed traditional "insurers" - entities such as HMOs and provider-sponsored integrated health delivery networks - those entities, within the confines of Kentucky's insurance code, do transact business within the insurance industry and are regulated by the Commissioner of Insurance. As the Ninth Circuit recognized in Gregoire,

> The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, but this is a distinction without a difference. In the end, HMOs function the same way as a traditional health insurer: The Policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance."

1998 WL 318759 at *5 (citations omitted), rev'g, Gregoire, 967 F. Supp, at 430 ("While the status of an HMO is a gray area because it possesses certain characteristics of insurance and health care, it appears that its primary mission is health care as opposed to insurance."). Thus, the Court finds that like the mandated-benefit statute in Metropolitan Life Ins. Co., the AWP statutes "impose requirements only on insurers, 105 S.Ct. at 2391. "To hold otherwise would require the Court to recognize form over substance and to refuse to recognize the natural evolution of the health insurance industry," Community Health Partners Inc., 1998 WL 325259 at *13.

Moreover, even if the Court were to agree that the AWP statutes were not directed solely at the insurance industry, see Texas Pharmacy Ass'n, 105 F.3d at 1038-39, CIGNA Healthplan, 82 F.3d at 650, Prudential Ins. Co., 964 F. Supp. at 1298-99; Hayden, 843 F. Supp. at 1436, the Court still holds that the AWP statutes are "saved" since none of the above factors are dispositive and the common-sense view is that the AWP statutes regulate the business of insurance. Again, the Court finds Metropolitan Life Ins. Co. instructive.

In Metropolitan Life Ins. Co., the Supreme Court clearly found unpersuasive the insurers arguments that the mandated-benefit law in question was in reality a health law and not a "traditional" insurance law intended to be saved by, § 514 (b)(2)(A)." 105 S.Ct. 2390. In addressing the insurers argument, the Court emphasized,

> Initially, nothing in § 514(b)(2)(A), or in the "deemer clause" which modifies it; purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind.

Appellants assert that state laws that directly regulate the insurer, and laws that regulate such matters as the way in which insurance may be sold, are traditional laws subject to the clause, while laws that regulate the substantive terms of insurance contracts are recent innovations more properly seen as health laws rather than as insurance laws, which § 514(b)(2)(A) does not save. **This distinction reads the savings clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not "relate to" benefit plans in the first instance. Because they would not be pre-empted by § 514(a), they do not need to be "saved" by § 514(b)(2)(A).** There is no indication that Congress could have intended the saving clause to operate only to guard against too expansive readings of the general preemption clause that might have included laws wholly unrelated to plans. Appellants' construction, in our view, violates the plain meaning of the statutory language and renders redundant both the saving clause it is construing, as well as the deemer clause which it precedes, and accordingly has little to recommend it.

Moreover, it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws. As we have indicated, state laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70's, when Congress considered ERISA. The case law concerning the meaning of the phrase "business of insurance" in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws "which regulate insurance."

Id. at 2390-91 (emphasis added) (internal footnotes omitted). Thus, having found that the AWP statute "regulates" insurance, the statute is "saved" from preemption."[10]

SUMMATION

The plaintiffs have standing to bring this action. The AWP statutes do "relate to" ERISA plans, and therefore are preempted if they are not "saved" by ERISA's savings clause. Because the statute "regulates" insurance both within

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[10] Although this issue is not squarely before the Court, the Court notes that the "deemer clause" provides that an employee benefit plan cannot be saved under the "saving" clause as such plan is not considered to be under the "business of insurance." Thus, the Supreme Court has noted that a difference exists between insured and uninsured plans.

> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance, regulations insofar as they apply to the plan's insurer.

FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403, 409 (1990). Consequently, insofar as the AWP statutes are "saved" from preemption, the AWP statutes cannot regulate uninsured employee benefit plans and such plans are preempted.

the meaning of the McCarran-Ferguson Act and the common-sense view, the statutes are "saved" from preemption.

Accordingly, with the Court being sufficiently advised,

IT IS ORDERED:

(1) the plaintiffs' motion for partial summary judgment [Record No. 24] be, and the same hereby is, **DENIED.**

(2) the defendant's motion for partial summary judgment [Record No. 36] be, and the same hereby is; **GRANTED.**

This the 6th day of August, 1998.

/s/
JOSEPH M. HOOD, JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
FRANKFORT

CIVIL ACTION NO. 97-24

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC., ET AL., PLAINTIFFS,

v.

GEORGE NICHOLS, III, in his Official Capacity as Commissioner of the Kentucky Department of Insurance, DEFENDANT.

* * * * * * * * *

This matter is before the Court on Plaintiffs' unopposed motion for partial final judgment under Fed. R. Civ. P. 54(b) or alternatively, certification under 28 U.S.C. § 1292(b) [Record 45], and being advised,

IT IS HEREBY ORDERED:

(1) That Plaintiffs' motion for final judgment under Fed. R. Civ. P. 54(b) be, and the same hereby is, **GRANTED;**

(2) that the Court's Order dated August 6, 1988 [Record No. 43] is **FINAL AND APPEALABLE** and **THERE IS NO JUST CAUSE FOR DELAY**.

This is the 17th day of September, 1998. [Filed Sept. 18, 1998.]

/s/
JOSEPH M. HOOD, JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF KENTUCKY
FRANKFORT DIVISION

CIVIL ACTION NO. 97-24

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC., ADVANTAGE CARE, INC., AETNA HEALTH PLANS OF OHIO, INC., CHOICECARE HEALTH PLANS, INC., FHP OF OHIO, INC., HMPK, INC., PLAN, INC., and HUMANA HEALTH PLAN, INC., PLAINITFFS,

v.

GEORGE NICHOLS III, in his capacity as Commissioner of the Kentucky Department of Insurance, DEFENDANT.

JUDGMENT

Plaintiffs having moved for partial summary judgment pursuant to Fed. R. Civ. P. 56 on Count 1 of their Complaint, and defendant having cross-moved from partial summary judgment pursuant to Fed. R. Civ. P. 56 on Count 1, and the said motions having come before the Honorable Joseph M. Hood, United States District Judge, and the Court thereafter on August 6, 1998 having handed down its opinion granting defendant's motion and denying plaintiffs' motion, it is hereby

ORDERED, ADJUDGED, AND DECREED: That Count I of plaintiff's Complaint is dismissed.

Dated: September 22, 1998

/s/
Hon. Joseph M. Hood

APPENDIX E

98-6308

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL.,

Plaintiffs-Appellants,

v. ORDER

GEORGE NICHOLS, III, IN HIS OFFICIAL CAPACITY AS COMMISSION OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Defendant-Appellee.

BEFORE: KENNEDY and NORRIS, Circuit Judges; and HOLSCHUH,* District Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issue raise din the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

[Nov. 20, 2001] /s/
Leonard Green, Clerk

* Hon. John D. Holschuh, Senior District Judge for the Southern District of Ohio, sitting by designation.

APPENDIX F

STATUTORY PROVISIONS INVOLVED

ERISA PREEMPTION PROVISIONS

ERISA's preemption provision, which includes the "savings" clause and the "deemer" clause, is codified at 29 U.S.C. § 1144, and provides in pertinent part:

Section 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

KENTUCKY GENERAL AWP LAW

Kentucky's general AWP statute provides in pertinent part:

304.17A-005 DEFINITIONS FOR SUBTITLE

As used in this subtitle, unless the context requires otherwise:

* * *

(23) "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical- surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

* * *

304.17A-270 NONDISCRIMINATION AGAINST PROVIDER IN GEOGRAPHIC COVERAGE AREA

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

* * *

KENTUCKY CHIROPRACTIC AWP LAW

Kentucky's chiropractic AWP law provides:

304.17A-171 REQUIREMENTS FOR HEALTH BENEFIT PLANS THAT INCLUDE CHIROPRACTIC BENEFITS

A health benefit plan that includes chiropractic benefits

shall:

(1) Include all primary chiropractic providers who are selected by covered persons of the plan for the provision of all chiropractic benefits provided by the plan which fall within the statutory scope of practice of the respective primary chiropractic provider.

(2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

(3) Guarantee that all covered persons who are eligible for chiropractic benefits under a health benefit plan shall have direct access to the primary chiropractic provider of their choice independent of, and without referral from, any other provider or entity.

(4) Assure that those plans utilizing a gatekeeper system shall designate the primary chiropractic provider within the scope of practice as the gatekeeper, who shall provide basic patient care and coordinate diagnostic testing, indicated treatment, and specialty referral for those covered persons in the provision of chiropractic benefits. Nothing in KRS 304.17A-170 or this section shall prevent a covered person from having direct access to that person's primary care provider (gatekeeper) for treatment and being reimbursed in accordance with the terms and fee schedule of the health benefit plan.

(5) Not discriminate between individual providers or classes of providers in the amount of reimbursement, copayment, or other financial compensation for the same or essentially similar services provided by the health benefit plan.

(6) Not promote or recommend any individual provider or class of providers to a covered person by any method or means.

(7) Assure that an adequate number of primary chiropractic providers are included as participating chiropractic providers to guarantee reasonable accessibility, timeliness of care, convenience, and continuity of care to covered persons.

(8) Make available to covered persons a listing of all participating primary chiropractic providers, their practice location and telephone number on a regular, timely basis.